HPHC Insurance Company, Inc.

Benefit Handbook

Medicare Enhance Plan

(A Medicare Plan for Retirees)

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Medicare Enhance is a product of HPHC Insurance Company, Inc.,
a wholly owned subsidiary of Harvard Pilgrim Health Care, Inc.

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I. INTRODUCTION

Medicare Enhance (the "Plan") is a product of HPHC Insurance Company, Inc. ("HPIC"), a subsidiary of Harvard Pilgrim Health Care, Inc. ("Harvard Pilgrim"). HPIC has authorized Harvard Pilgrim to perform, on its behalf, administrative functions such as Member Services and claims processing for Plan Subscribers.

This *Benefit Handbook* describes the benefits and the terms and conditions of coverage under the Plan. The Plan is designed to compliment a Subscriber's Medicare coverage by:

1. Paying most Medicare deductible and coinsurance amounts for Medicare covered services;
2. Covering certain services that Medicare does not cover at all; and
3. Paying for some Medicare covered services after your Medicare benefits have been exhausted.

To use Plan benefits, simply obtain services from any health care Provider eligible for payment by Medicare. (A few cases in which you do not need to use a Provider eligible for payment by Medicare are described in Section III.D, below.) Please see Section II of this Handbook for further information on how to use the Plan.

To understand your Medicare Enhance benefits fully, you should read the Medicare program handbook *Medicare and You*. *Medicare and You* describes your Medicare benefits in detail.

To learn more about health coverage for people with Medicare you may want to review the *Guide to Health Insurance for People with Medicare*. You may obtain Medicare publications at most Social Security Offices or by calling Medicare at **1-800-633-4227**. (TTY service is available at **1-877-486-2048**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: **http://www.medicare.gov/publications/home.asp**

Changes in Medicare benefits or the Medicare program itself may result in changes to this *Benefit Handbook*. HPIC is not responsible for notifying the GIC or Subscribers for changes in Medicare benefits or in the Medicare program. In the event such changes affect the terms and conditions of this *Benefit Handbook* or Plan benefits, the GIC will be notified and Subscribers will be sent any necessary amendment(s) to this *Benefit Handbook*.

PLEASE NOTE THAT THIS MEDICARE ENHANCE PLAN IS ONLY AVAILABLE TO SUBSCRIBERS ENROLLED THROUGH THE GIC. IF A SUBSCRIBER'S ELIGIBILITY FOR GIC COVERAGE ENDS, ENROLLMENT IN THE PLAN MUST ALSO END.

The Massachusetts Managed Care Reform Law requires disclosure of premium information and information concerning HPIC's voluntary and involuntary disenrollment rate. This information including the specific premium amount paid on your behalf by the GIC will be sent to you in a separate letter. Please keep that letter with this *Benefit Handbook* for your records.

Contacting Member Services
You may contact a Plan Member Services representative by calling **1-888-333-4742**. Deaf and hard-of-hearing Subscribers who have access to a Teletypewriter ("TTY") may communicate directly with the Member Services Department by calling our TTY machine at **1-800-637-8257**.

Non-English speaking Subscribers may also call our Member Services Department at **1-888-333-4742** to have their questions answered. Harvard Pilgrim offers free language interpretation services in more than 120 languages.

The Office of Patient Protection.
The Office of Patient Protection of the Department of Public Health is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection can be reached at:

Department of Public Health
Office of Patient Protection
250 Washington Street
Boston, MA 02108

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site: http://www.state.ma.us/dph/opp/index.htm

The following information is available to consumers from the Office of Patient Protection:

1) A list of sources of independently published information assessing Subscribers' satisfaction and evaluating the quality of health care services offered by a carrier;
2) The percentage of physicians who voluntarily and involuntarily terminated participation in contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;
3) The percentage of premium revenue expended by the carrier for health care services provided to Subscribers for the most recent year for which information is available;
4) A report detailing, for the previous calendar year, the total number of: a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

Physician Profiling Information
The Commonwealth of Massachusetts Board of Registration in Medicine maintains Internet websites with physician profiling information at **www.massmedboard.org.**

You can also write the Board of Registration in Medicine at the following address:

Board of Registration in Medicine
560 Harrison Avenue
Suite G4
Boston, MA 02118

(617) 654-9800

Pre-existing Conditions
The Plan does not impose any restrictions, limitations, or exclusions on your benefits that are related to preexisting conditions.

[Spanish]

Los miembros que no dominan el inglés pueden llamar al Departamento de servicios para miembros de Harvard Pilgrim Health Care al 1-888-333-4742, donde se responderá a sus preguntas. El Plan ofrece un servicio de interpretación gratuito en más de 120 idiomas.

[Russian]

Те, кто не владеет английским языком, могут также получить ответы на свои вопросы, позвонив по телефону 1-888-333-4742 в отдел обслуживания медицинского центра Harvard Pilgrim. Данный план предоставляет бесплатные услуги по обеспечению устного перевода более, чем на 120 иностранных языков.

[Arabic]

كما يستطيع الأعضاء الغير الناطقين باللغة الإنجليزية أن يتصلوا بقسم خدمات الأعضاء بهيئة هارفارد بيلجريم (Harvard Pilgrim) للعناية الصحية ، وذلك للحصول على الرقم 1-888-333-4742 على إجابات لاستفساراتهم. ويقدم البرنامج خدمات ترجمة مجانية بأكثر من 120 لغة.

[Portuguese]

Os membros que não falarem inglês também podem telefonar para o Departamento dos Serviços de Saúde Harvard Pilgrim para membros através do número 1 888 333 4742, de forma a obterem os esclarecimentos pretendidos. Este plano oferece serviços de interpretação gratuitos em mais de 120 idiomas.

[French]

Harvard Pilgrim Health Care propose des services d'interprétation gratuits dans plus de 120 langues pour répondre aux questions des membres qui ne parlent pas anglais. Pour utiliser ce service, appelez la section des services aux membres au 1-888-333-4742.

[Greek]

Τα Μέλη που δε μιλούν Αγγλικά μπορούν επίσης να τηλεφωνήσουν στο Τμήμα Εξυπηρέτησης Μελών του Harvard Pilgrim Health Care στον αριθμό 1-888-333-4742 για τυχόν ερωτήσεις. Το Πρόγραμμα παρέχει δωρεάν ξενόγλωσσες υπηρεσίες διερμηνείαςγια περισσότερες από 120 γλώσσες.

[Haitian Creole]

Manm yo ki pa pale Angle ka rele Depatman Sèvis Manm Harvard Pilgrim Health Care tou nan 1-888-333-4742 pou jwenn repons a keksyon yo. Plan an ofri sèvis entèpretasyon gratis nan plis ke 120 lang.

[Italian]

I Partecipanti che non parlano inglese possono anche rivolgere le proprie domande al Reparto Servizi Partecipanti dell'Harvard Pilgrim Health Care, chiamando il numero 1-888-333-4742. Il Piano offre servizi di interpretariato gratuiti in oltre 120 lingue.

[Traditional Chinese]

不說英語的會員亦可致電 1-888-333-4742，請 Harvard Pilgrim 醫療保健的 會員服務部門回答所提出的問題。該計劃免費提供120多種語言的翻譯服務。

[Lao]

ສະມາຊິກ ທັງ ຫລາຍ ທີ່ ປາກ ພາສາ ອັງກິດ ຍໍ ສັ່ນສົ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະແນກ ບໍລິການ ລູກ ຄ້າ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ **Harvard Pilgrim** ໄດ້ ໂດຍ ໂທ ໄປ ຫາ **1-888-333-4742** ເພື່ອ ຂໍ ຊາບ ຄໍາ ຕອບ ຂອງ ຄໍາ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນີ້ ຂໍ ສະເ ໜີ ບໍລິການ ແປ ພາສາ ໃນ ຫລາຍ ກວ່າ **120** ພາສາ ໂດຍ ່ ຄິດ ຄ່າ ບໍລິການ ໃດໆ ທັງ ສິ້ນ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស
ក៏អាចទូរស័ព្ទទៅការិយាល័យផ្នែកសេវាបំរើសមាជិកនៃ
ផែនការសុខភាព **Harvard Pilgrim**
Health Care លេខ **1-888-333-4742**
ដើម្បីឲ្យគេឆ្លើយសំនួរចំងល់ផ្សេងៗ ។
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Non-English speaking Subscribers may also call Harvard Pilgrim Health Care's Member Services Department at **1-888-333-4742** to have their questions answered. The Plan offers free language interpretation services in more than 120 languages.

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II. ABOUT THE PLAN

A. HOW TO USE THIS BENEFIT HANDBOOK

1. THE DOCUMENTS THAT EXPLAIN YOUR COVERAGE

This *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* make up the legal agreement stating the terms and conditions of the Plan. The *Benefit Handbook* contains most of the details of your coverage. The *Schedule of Benefits* states the Copayments and any other charges that apply to the GIC's plan. It also may be used as a brief summary of your benefits.

The Plan's coverage for prescription drugs is described in your *Prescription Drug Brochure*. It is important that you read that document to understand how to obtain medications at the lowest out-of-pocket cost to you.

In writing these documents, we have tried to provide you with all of the information you need to make full use of your benefits under the Plan. You may use these documents to learn:

- What is covered;
- What is not covered;
- Any limits or special rules for coverage;
- Any Copayments or other charges you have to pay for Covered Services; and
- Procedures for filing claims and obtaining reimbursement for services.

2. WORDS WITH SPECIAL MEANING

Some words in this *Benefit Handbook* have special meanings. When we use one of these words, we capitalize it. We list such words and what they mean in the Glossary at the end of this Handbook

3. HOW TO FIND WHAT YOU NEED TO KNOW

The *Benefit Handbook* begins with a table of contents that will help you find what you need to know.

We have also organized this *Benefit Handbook* with the most important things first. For example, the Plan's benefits are described in the next section. The list of services that are not covered, known as "exclusions," follow the description of the Plan's Benefits. Procedures for obtaining reimbursement follow the list of exclusions. As noted above, Copayments and other charges you need to pay are stated in the *Schedule of Benefits*.

4. INFORMATION ABOUT YOUR MEDICARE BENEFITS

Medicare Enhance complements the coverage you receive from the Medicare program. The information on Medicare benefits contained in this Handbook is only designed to help you make use of your benefits under the Plan. You should read the Medicare program handbook, *Medicare and You* for information on your Medicare benefits. You may obtain a copy of *Medicare and You* at most Social Security Offices and by calling Medicare at **1-800-633-4227**. (TTY service is available at **1-877-486-2048**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: **http://www.medicare.gov/publications/home.asp**

5. YOUR IDENTIFICATION CARD

Each Subscriber receives an identification card. The card contains important information about your coverage. It must be presented along with your Medicare card whenever you receive health care services.

B. HOW MEDICARE ENHANCE WORKS

Medicare Enhance (the "Plan") provides GIC-sponsored health coverage for persons enrolled in Medicare Parts A and B. A Medicare eligible Spouse of an eligible Subscriber may also be enrolled if he or she meets the eligibility requirements of the Plan and the GIC. The Plan complements Medicare coverage by:

- Paying most Medicare deductible and coinsurance amounts for services covered by Medicare;
- Providing prescription drug coverage;
- Covering a number of preventive care services not covered by Medicare;
- Covering services received in a Medical Emergency outside the United States; and
- Covering a number of special services that are required to be provided under Massachusetts law.

The benefits of the Plan are explained in detail in Section III, below.

To use Plan benefits, simply obtain services from any health care Provider eligible for payment by Medicare. (A few cases in which you do not need to use a Provider eligible for payment by Medicare are described in Section III.D, below.) In the case of

Medicare covered services, your health care Provider will first bill Medicare for services you receive. You or your Provider may then submit a Medicare Summary Notice (MSN) to the Plan for payment of the Medicare deductible and coinsurance amount. In the case of services that are not covered by Medicare, the Plan may be billed directly by either you or your Provider. Please see Section V ("Reimbursement and Claims Procedures"), below, for a detailed explanation of the Plan's claim filing procedures.

C. COVERAGE IN A MEDICAL EMERGENCY

You are always covered for care you need in a Medical Emergency. In a Medical Emergency you may obtain services from a physician, a hospital, or a hospital emergency room. Within the United States, you are also covered for ambulance transportation to the nearest hospital that can provide the care you need. Please see your *Schedule of Benefits* for information on the Copayments that apply to the different types of emergency care.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

The Plan also covers care in a Medical Emergency that is received in a foreign country. Please see Section III.D.1 of this Handbook for a description of the Plan's coverage for services received outside of the United States. (Note that with very limited exceptions, Medicare does not cover any services received outside of the United States.)

A Medical Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

D. ACCESS TO INFORMATION AND CONFIDENTIALITY

The Subscriber agrees that, except where restricted by law, the Plan may have access to (1) all health records and medical data from health care Providers providing services covered under this *Benefit Handbook*, and (2) information concerning health coverage or claims from all Providers of motor vehicle insurance, medical payment policies, homeowners insurance and all types of health benefit plans.

The Plan is committed to ensuring and safeguarding the confidentiality of its Subscribers' information in all settings, including personal and medical information. The Plan staff access, use and disclose Subscriber information only in connection with providing services and benefits and in accordance with The Plan's confidentiality policies. The Plan permits only designated employees, who are trained in the proper handling of Subscriber information, to have access to and use of your information. The Plan sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to the Plan's confidentiality and privacy standards.

When you enrolled in the Plan, you consented to certain uses and disclosures of information which are necessary for the provision and administration of services and benefits, such as: coordinating care; conducting quality activities, including Subscriber satisfaction surveys and disease management programs; verifying eligibility; fraud detection; and certain oversight reviews, such as accreditation and regulatory audits. When the Plan discloses Subscriber information, it does so using the minimum amount of information necessary to accomplish the specific activity.

The Plan discloses Subscribers' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your *Benefit Handbook*. Whenever possible, the Plan discloses Subscriber information without individual identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. The Plan will not disclose to other third parties, such as your employer, Subscriber-specific information (i.e. information from which you are personally identifiable) without your specific consent

unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable law, the Plan and all of its contracted health care providers agree to provide Subscribers with access to, and a copy of, their medical records upon a Subscriber's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

E. SUBSCRIBERS' RIGHTS AND RESPONSIBILITIES

- Subscribers have a right to receive information about the Plan, its services, its practitioners and providers, and Subscribers' rights and responsibilities.
- Subscribers have a right to be treated with respect and recognition of their dignity and right to privacy.
- Subscribers have a right to participate with practitioners in decision-making regarding their health care.
- Subscribers have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Subscribers have a right to voice complaints or appeals about the Plan or the care provided.
- Subscribers have a responsibility to provide, to the extent possible, information that the Plan, practitioners and providers need in order to care for them.

Subscribers have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

III. COVERED BENEFITS

A. INTRODUCTION

This section describes the products and services covered by the Plan.

The Plan covers services in conjunction with your Medicare benefits. Medicare is the primary payer for Medicare covered services. The Plan will only provide coverage for such services after your Medicare benefits have been determined. The Plan also provides coverage for a number of services that Medicare does not cover. These services are described in Sections III.C ("Preventive Care Services") and III.D ("Additional Covered Services"), below.

To be covered by the plan, a product or service must meet each of the following basic requirements:

- It must be Medically Necessary;
- It must be received while the Member is enrolled as a Subscriber in the Plan;
- It must be either covered by Medicare or specifically listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure*; and
- It must not be listed as a product or service that is excluded from coverage by the Plan.

All coverage is subject to the Copayments listed in the *Schedule of Benefits*. Payments by the Plan are limited to the Payment Maximum described in Section V ("Reimbursement and Claims Procedures") and the Glossary. The Subscriber is responsible for any amount billed by a Provider that is in excess of the Payment Maximum.

B. SERVICES COVERED BY MEDICARE

This section describes your benefits for services that are covered by the Medicare program. The Plan covers the Medicare deductible and coinsurance amounts for most Medicare covered services. The only services covered by Medicare for which no coverage is provided by the Plan are the services specifically listed as exclusions in Section IV ("Exclusions from Coverage"), below. In all cases, the decision of the Medicare program to provide coverage for a service must have been made before any Plan benefits will be payable under this section. No coverage will be provided by the Plan for any service denied by Medicare unless the service is specifically listed in Sections III.C or III. D, below.

The following is a summary of the services covered by Medicare. (Please see "*Medicare and You*" for additional information on Medicare coverage.) When Medicare covers a service but does not pay the full amount, the Plan covers the applicable Medicare coinsurance and deductible amounts up to the Payment Maximum. The only Medicare covered services for which no coverage is provided by the Plan are those specifically listed as exclusions from coverage in Section IV of this Handbook.

1. INPATIENT SERVICES

a. Hospital Care

Medicare coverage for Hospital inpatient care is determined by Benefit Periods. There is no limit to the number of Benefit Periods covered by Medicare during your lifetime. However, Medicare benefits for inpatient Hospital care are limited to 90 days during a Benefit Period. If you exhaust the 90-day limit, you can elect to use up to 60 additional days of inpatient Hospital care from your Medicare "lifetime reserve days." These are non-renewable days of hospital coverage that you may use only once in your life.

Most hospital care covered by Medicare may be obtained at any Medicare certified Hospital, including a psychiatric hospital. However, liver, lung, heart and heart-lung transplants must be obtained at a Hospital that has been approved by Medicare for the type of transplant required. These Hospitals are required to meet strict quality standards. Neither Medicare nor the Plan will provide any coverage for a liver, lung, heart or heart-lung transplant that is not provided at a Medicare approved transplant Hospital.

If you exhaust the 190-day Medicare limit for inpatient services in a psychiatric hospital, you may be eligible for additional coverage for inpatient care beyond the Medicare limit. See Section III.D.2. below.

The Plan will provide the following coverage in connection with semi-private room and board and Special Services for Medicare covered inpatient Hospital services:

i. **Deductible:** The Plan will pay the Medicare Part A deductible amount applicable to the 1st day of hospitalization through the 60th day of hospitalization in each Benefit Period.

ii. **Coinsurance:** The Plan will pay the Medicare Part A daily coinsurance amount from the 61st day of hospitalization through the 90th day of hospitalization in each Benefit Period.

iii. **Lifetime Reserve Days Coinsurance:** The Plan will pay the Medicare lifetime reserve days daily coinsurance amount from the 91st day of hospitalization in each Benefit Period for each of the 60 Medicare lifetime reserve days used.

Benefits for Non-Medicare Covered Hospital Services. The Plan provides coverage for care in an acute or rehabilitation Hospital in excess of the Medicare limits described above, which is listed in the *Schedule of Benefits*. Benefits for Hospital care in excess of Medicare limits will only be paid by the Plan if: (1) the Hospital services are Medically Necessary as determined by the Plan, and (2) all 60 Medicare Lifetime Reserve Days have been used.

b. Care in a Skilled Nursing Facility (SNF)

The Plan covers the Medicare deductible and coinsurance amounts for Medicare covered care in a Skilled Nursing Facility (SNF). Medicare covers up to 100 days per Benefit Period in a Medicare certified SNF. To be eligible for coverage, all rules applicable to Medicare coverage of SNF care must be met. These include the following:

- The Subscriber needs skilled nursing or rehabilitative care;
- The care is required on a daily basis;
- The care can, as a practical matter, only be provided in an inpatient setting; and
- The Subscriber must have been an inpatient in a Hospital for at least three days and enter the SNF within 30 days after Hospital discharge.

There is no coverage for care received in a SNF that does not meet Medicare coverage rules, including the requirements stated above.

The following is a description of the coverage provided by the Plan for care in a Medicare certified SNF:

i. **First 20 Days:** Medicare covers from the 1st day of inpatient services through the 20th day of inpatient services in each Benefit Period. No coverage is provided by the Plan.

ii. **Coinsurance:** The Plan will cover the Medicare Part A daily coinsurance amount for a semi-private room and board and Special Services from the 21st day of inpatient services through the 100th day of inpatient services in each Benefit Period.

c. Care in a Religious Nonmedical Health Care Institution

The Plan will cover the Medicare Part A coinsurance and deductible amounts for inpatient care in a Religious Nonmedical Health Care Institution (RNHCI), such as a Christian Science Sanatorium. All Medicare conditions and limitations on the coverage of services in a RNHCI also apply to the coverage provided by the Plan. Religious aspects of care provided in RNHCIs are not covered.

2. OUTPATIENT SERVICES

a. Emergency Room Care

The Plan will pay the Medicare coinsurance and deductible amounts for Medicare covered services provided at a hospital emergency room or other emergency facility.

b. Services of Physicians and Other Health Professionals

The Plan will pay the Medicare coinsurance and deductible amounts for Medicare covered services provided by physicians and other health professionals entitled to coverage by the Medicare program. Such health professionals include, but are not limited to, certified nurse-midwives, chiropractors, clinical social workers, clinical psychologists, dentists, nurse anesthetists, nurse practitioners, occupational therapists, physical therapists, physicians' assistants, podiatrists and speech therapists. Please see Section III.B.2.j, below, for additional information on your coverage for physical, occupational and speech therapy.

Medicare coverage includes unlimited visits with mental health professionals eligible for payment by Medicare. These include physicians, clinical psychologists and clinical social workers.

Please note that very limited coverage is provided for the services of chiropractors and dentists. Medicare only covers the services of chiropractors for manual manipulation of the spine to correct a spinal subluxation demonstrated to exist by x-ray. Please see Section III.B.2.l ("Dental Care and Oral Surgery") for the circumstances under which the services of a dentist may be covered.

The services of podiatrists are covered by Medicare to treat injuries and diseases of the foot. Neither Medicare nor the Plan will cover most routine foot care, such as cutting of nails, the trimming of corns and bunions or the removal of calluses. However, Medicare does cover routine foot care that is Medically Necessary due to circulatory system disease, such as diabetes.

c. Diagnostic Tests and Procedures

The Plan will pay the Medicare coinsurance and deductible amount for Medicare covered diagnostic laboratory tests, X-ray examinations and other diagnostic procedures.

d. Medical Therapies

The plan will pay the Medicare coinsurance and deductible amounts for Medicare covered therapeutic services including surgery, radiation therapy for cancer, and therapy for any condition for which isotopes, radium, or radon seeds are used. Also covered are chemotherapy and immunosuppressive drugs (and their administration) when such medications cannot be self-administered. (Please see your *Prescription Drug Brochure* for information on your coverage of self-administered medications.)

Medicare covered therapeutic services include post-mastectomy coverage for: (1) surgical reconstruction of the breast on which the mastectomy was performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) physical complications for all stages of mastectomy, including lymphedemas, in a manner determined by the attending physician and the patient.

e. Durable Medical Equipment and Prosthetic Devices

The plan will pay the Medicare coinsurance and deductible amounts for Medicare covered durable medical equipment and prosthetic devices. Medicare coverage is provided only for equipment or devices that are Medically Necessary for the treatment of illness or injury or to improve the functioning of a malformed body part.

Durable medical equipment is defined by Medicare as equipment which: (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful in the absence of illness or injury, and (4) is appropriate for use in the home. Examples of such equipment include oxygen and oxygen equipment, blood glucose monitors, hospital beds, crutches and canes.

Medicare defines prosthetic equipment as a device that replaces an internal body organ. Examples of such devices include prosthetic hands, prosthetic legs, cardiac pacemakers, prosthetic lenses, breast prostheses (including mastectomy bras) and eyeglasses or contact lenses after cataract surgery.

No coverage is provided for equipment that is not covered by Medicare, including, but not limited to, dentures or dental appliances.

f. Home Health Care

Medicare provides coverage for Medically Necessary home health services if you are confined to home. Services covered by Medicare may include intermittent skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, nutritional counseling, the services of a home health aid, medical supplies and durable medical equipment. A Medicare Participating Home Health Agency must provide home health care services.

Since no Medicare deductible or coinsurance amounts apply to home health care (other than durable medical equipment), no additional coverage for home health care is provided by the Plan except the following:

i. The Plan covers Medicare coinsurance and deductible amounts for Medicare covered durable medical equipment furnished in connection with the home health care services. Please see Section III.B.2.e, above, for information on benefits for durable medical equipment.

ii. The Plan covers home infusion therapy when Medicare coverage is not available. Please see Section III.D.12, below, for information on this benefit.

g. Ambulance Services

The Plan will pay the Medicare Part B coinsurance and deductible amount for Medicare covered ambulance transportation. Medicare covers ambulance services only if the ambulance provider meets Medicare requirements and transportation by any other vehicle would endanger your health. In general, Medicare benefits are only provided for transportation between the following locations, (1) home and a hospital, (2) home and a skilled nursing facility (SNF), or (3) a hospital and a skilled nursing facility.

h. Hospice Care

Medicare covers hospice services for a Subscriber with a Terminal Illness, when provided by a Medicare certified hospice. The Plan will provide coverage for Medicare deductible and coinsurance amounts for Medicare covered hospice care.

i. Kidney Dialysis

The Plan will pay the Medicare coinsurance and deductible amounts for Medicare covered kidney dialysis.

j. Physical, Occupational and Speech Therapy

The Plan will pay the Medicare coinsurance and deductible amounts for Medicare covered physical, occupational and speech therapy. In order to be covered by Medicare a physician must certify that: (1) the patient required the therapy, (2) a plan of care has been established, and (3) the services were provided while the patient was under the care of a physician. (Additional coverage for the diagnosis and treatment of speech, hearing and language disorders may be available for services not covered by Medicare. Please Section III.D.9, below, for further information.)

k. Partial Hospitalization

The Plan will pay the Medicare coinsurance and deductible amounts for Medicare covered partial hospitalization for mental health and drug and alcohol abuse rehabilitation. Partial hospitalization services are an acute level of care that is more intensive than traditional outpatient services, but less intensive than 24-hour care. Medicare covers partial hospitalization when inpatient care would otherwise be required. Programs providing primarily social, recreational or diversionary activities are not covered.

l. Dental Care and Oral Surgery

Medicare does not cover Dental Services. However, Medicare has determined that certain services provided by dentists or oral surgeons are primarily medical in nature and therefore eligible for Medicare coverage. The following are examples of services that are generally eligible for coverage by Medicare:

- The extraction of teeth to prepare the jaw for radiation treatment for neoplastic disease.
- Surgery of the jaw or related structures.
- Setting fractures of the jaw or facial bones.
- Services of a dentist that would be covered if provided by a physician, such as the treatment of oral infections and tumors.
- Dental examinations to diagnose an infection that would contraindicate surgery.

The Plan will pay the Medicare coinsurance and deductible amounts for the services of dentists and oral surgeons that have been covered by Medicare. No other Dental Services are covered.

m. Prescription Drug Coverage

The GIC has purchased coverage for prescription drugs, and that coverage is described in the *Prescription Drug Brochure* you received with this *Benefit Handbook*. The Plan provides benefits for most prescription medications, subject to the Copayments listed on your Plan ID card. Please see the *Prescription Drug Brochure* for the details of the coverage provided.

The Plan also pays the Medicare coinsurance and deductible amounts for any drug that is covered by Medicare. However, Medicare drug coverage is limited. In general, it includes (1) drugs that cannot be self-administered, and (2) specific drugs for which coverage is provided in accordance with federal law.

When Medicare criteria are met, Medicare covered medications may include: (1) Pneumococcal pneumonia vaccine, (2) Hepatitis B vaccine, (3) Influenza virus vaccine, (4) Hemophilia clotting factors, (5) antigens, (6) certain immunosuppressive drugs, (7) Erythropoitin (EPO), (8) certain injectable drugs for Osteoporosis, and (9) certain oral chemotherapy and anti-emetic medications.

This list is provided for informational purposes only and does not include all Medicare covered drugs. Specific information on the drugs covered by Medicare and the criteria for coverage must be obtained from the Medicare program.

n. Coverage for Clinical Trials

The plan will pay the Medicare coinsurance and deductible amounts for Medicare covered services received during participation in a clinical trial. Please see the Medicare publication "Medicare & Clinical Trials," available from the Center for Medicare and Medicaid Services (CMS), for information on the Medicare coverage requirements for clinical trials.

C. PREVENTIVE CARE SERVICES

This section lists the preventive care services covered by either Medicare or the Plan. In some cases, Medicare coverage may be available for part of a service, the remainder of which is covered by the plan. (For example, Medicare does not cover physical examinations but does cover Pap Tests, pelvic examinations and clinical breast examinations at least every two years.) If Medicare coverage is available for any service listed below, the Plan will pay the Medicare coinsurance and deductible amount. If Medicare coverage is not available, the Plan will cover the service minus any Copayment up to the Payment Maximum.

1. PHYSICIAN'S SERVICES

The Plan provides coverage, less any payments by Medicare, for the following preventive care services:

a. An annual physical examination by a licensed physician, including education in self-care, blood pressure check, Pap Test and pelvic examination, clinical breast examination, fecal occult blood test, prostate cancer screening, nutritional counseling, and routine laboratory and blood tests.

b. The following preventive care services are covered to the extent Medically Necessary: immunizations, diabetes screenings, cholesterol measurements, glaucoma screening, prenatal and postpartum care and screenings for sexually transmitted diseases.

2. DIAGNOSTIC TESTS AND PROCEDURES

The Plan or Medicare covers the following diagnostic tests, in addition to the preventive care services listed above, to the extent Medically Necessary:

a. Colorectal cancer screening, including flexible sigmoidoscopy, colonoscopy, and barium enema;

b. Bone Mass Measurements;

c. Vision examinations including glaucoma screening; and

d. Hearing examinations.

Coverage is also provided for a baseline mammogram for women between ages 35 and 40 and an annual mammogram for women 40 years of age and older.

D. ADDITIONAL COVERED SERVICES

This section lists additional Plan benefits that are generally not covered by Medicare. If Medicare coverage is available for any service listed below, the coverage provided by the Plan is reduced by the Subscriber's Medicare benefits.

1. SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

This section describes the Plan's coverage for services received outside of the United States and its territories. (Generally, Medicare only covers services received within the United States.) Please note that the Plan's coverage is intended for persons living in the United States who travel to other countries. It is not intended for persons living outside the United States.

The Plan covers services received outside of the United States to care for an unexpected Medical Emergency that takes place while traveling away from home. Covered services include, but are not limited to, Medically Necessary emergency room care, physician services, and hospital care immediately following a Medical Emergency. Transportation by ambulance is covered only for a road ambulance from the place where a Medical Emergency takes place to the nearest hospital.

A Medical Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

No benefits will be provided for any service received outside of the United States that is: (1) a routine or preventive service of any kind, (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans, (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital, or (4) a service that would not be covered by Medicare or the Plan in the United States.

2. MASSACHUSETTS MANDATED COVERAGE FOR MENTAL HEALTH CARE AND DRUG AND ALCOHOL REHABILITATION SERVICES

The Plan provides coverage for Medicare coinsurance and deductible amounts for mental health and drug and alcohol abuse rehabilitation services covered by Medicare. The Plan also covers additional benefits for such services that are mandated by Massachusetts law. Your Massachusetts mandated coverage, explained in this subsection: (1) allows you to receive coverage for services provided by certain Providers that are not eligible for payment by Medicare, (2) provides you with minimum benefits you may use if Medicare coverage is not available, and (3) provides you with special benefits that may increase your coverage for certain medical conditions.

When Medicare coverage is available for any of the services listed below, the Plan will cover only the applicable Medicare coinsurance and deductible amounts. When Medicare does not cover a service listed, payment for Covered Services shall be made by the Plan up to the Payment Maximum, minus any applicable Copayment.

a. Covered Inpatient and Outpatient Facilities

The Medicare covered services described in Section III.B, above, are only available from Providers who are eligible to bill Medicare for Covered Services. The Massachusetts mandated mental health and drug and alcohol abuse rehabilitation services may be obtained from any of the following types of Providers.

Inpatient Care and Intermediate Care: In addition to Medicare certified institutions, the Plan will cover the Massachusetts mandated mental health and drug and alcohol abuse rehabilitation services described in this section on an inpatient basis or in intermediate levels of care (see page 15) at a partial hospitalization program at any Inpatient Mental Health Facility. An Inpatient Mental Health Facility is any one of the following types of institutions:

- A general Hospital licensed to provide such services;
- A facility under the direction and supervision of the Massachusetts Department of Mental Health;
- A private mental hospital licensed by the Massachusetts Department of Mental Health; or
- A substance abuse facility licensed by the Massachusetts Department of Public Health.

Outpatient Care: The Plan will cover the Massachusetts mandated mental health and drug and alcohol abuse rehabilitation services described in this section on an outpatient basis at any of the following:

- A licensed hospital;
- A mental health or substance abuse clinic licensed by the Massachusetts Department of Public Health;
- A public community mental health center;
- A professional office; or
- Home-based services.

To be covered, a Licensed Mental Health Professional acting within the scope of his or her license must render such services. A "Licensed Mental Health Professional" is any one of the following types of providers: physicians; psychologists; psychiatrists; psychiatric social workers; certified psychiatric nurses; psychotherapists; licensed independent clinical social workers; licensed nurse mental health clinical specialists; licensed mental health counselors; or clinical specialists in psychiatric and mental health nursing.

b. Minimum Benefits for Mental Health and Drug Abuse and Alcohol Rehabilitation Services

Massachusetts law provides minimum benefits for mental health and drug and alcohol rehabilitation services. Although Medicare generally provides coverage that is more extensive than the minimum benefits, there are some circumstances in which no Medicare coverage is available. This might happen: (1) where a Subscriber had used all of his or her Medicare covered inpatient days (described above in Section III.B.1.a, "Hospital Care"), or (2) where a Subscriber wanted to receive care from a provider, such as a licensed Mental Health Counselor, who is not eligible for payment by Medicare. In such cases, when services are Medically Necessary and Medicare coverage is not available, the Plan will provide coverage for mental health and drug and alcohol rehabilitation services as follows:

Minimum Benefits for Mental Health Services. The Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of all mental disorders, which are described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), as follows:

i. Inpatient Treatment: The Plan will cover Medically Necessary inpatient mental health treatment when provided at an Inpatient Mental Health Facility.

ii. Intermediate Care: The Plan will cover Medically Necessary Intermediate Care mental health treatment such as partial hospitalization, intensive outpatient and acute residential and day treatment.

iii. Outpatient Treatment: The Plan will cover Medically Necessary outpatient mental health services rendered by a Licensed Mental Health Professional**.**

Minimum Benefits for Drug and Alcohol Rehabilitation. The Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of drug abuse and alcoholism as follows:

i. Inpatient Treatment: The Plan will cover Medically Necessary inpatient drug abuse and alcoholism treatment at a Mental Health Inpatient Facility.

ii. Intermediate Care: The Plan will cover Medically Necessary Intermediate Care drug abuse and alcoholism treatment such as partial hospitalization, intensive outpatient and acute residential and day treatment.

iii. Outpatient Treatment: The Plan will cover Medically Necessary outpatient drug abuse and alcoholism services when rendered by a Licensed Mental Health Professional.

d. Detoxification and Psychopharmacological Services

The Plan will provide coverage, less any payments made by Medicare, for detoxification and psychopharmacological services to the extent Medically Necessary.

e. Psychological Testing and Neuropsychological Assessment

The Plan will provide coverage, less any payments made by Medicare, for psychological testing and neuropsychological assessment to the extent Medically Necessary.

3. SPECIAL FORMULAS FOR MALABSORPTION

The Plan will provide coverage, less any payments made by Medicare, for nutritional formulas for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophogeal reflux, gastrointestinal motility, and chronic pseudo-obstruction. In order to be covered, formulas for these conditions must be ordered by a physician.

4. WIGS

The Plan will provide coverage of a scalp hair prosthesis (wig) up to the amount specified in the *Schedule of Benefits* when the treating physician provides the Plan with a written statement that the wig is Medically Necessary and needed as a result of treatment for any form of cancer or leukemia.

5. BONE MARROW TRANSPLANTS FOR BREAST CANCER

The Plan will provide coverage, less any payments made by Medicare, for autologous bone marrow transplants for metastasized breast cancer in accordance with the criteria established by the Massachusetts Department of Public Health.

6. LOW PROTEIN FOODS

The Plan covers low protein foods for inherited diseases of amino and organic acids up to the amount specified in the *Schedule of Benefits*.

7. DIABETES TREATMENT

The Plan will provide coverage, less any payments made by Medicare, for:

- Outpatient diabetes self-management training;
- Diabetic laboratory tests;
- Blood glucose monitors, including coverage for voice-synthesizers and visual magnifying aids when Medically Necessary for use of blood glucose monitors for the legally blind;
- Dosage gauges, injectors, lancet devices, and molded shoes needed to prevent or treat complications of diabetes;
- Insulin pumps and infusion devices; and
- Insulin, insulin syringes, insulin pump supplies, insulin pens with syringe, oral agents for controlling blood sugar, lancets, blood test strips, and glucose, ketone, and urine test strips.

Pharmacy items are subject to the prescription Copayment listed on your ID card.

8. CARDIAC REHABILITATION

The Plan will provide coverage, less any payments made by Medicare, for Medically Necessary inpatient and outpatient cardiac rehabilitation. Cardiac Rehabilitation is

a multidisciplinary treatment of persons with documented cardiovascular disease. It may be provided in a Hospital or outpatient setting, and must meet standards promulgated by the Commissioner of Public Health, including, but not limited to, outpatient treatment initiated within 26 weeks after the diagnosis of the disease.

9. SPEECH-LANGUAGE AND HEARING SERVICES

The Plan will provide coverage, less any payments made by Medicare, for diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary. To be covered, services must be provided by a state licensed speech-language pathologist or audiologist.

10. HUMAN LEUKOCYTE ANTIGEN TESTING

The Plan will provide coverage, less any payments made by Medicare, for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability. Such coverage will cover the costs of testing for A, B, or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and rules or regulations established by the Massachusetts Department of Public Health.

11. CONTRACEPTIVE SERVICES AND HORMONE REPLACEMENT THERAPY

The Plan provides coverage, less any payments made by Medicare, for outpatient professional services for the prevention of pregnancy and in connection with the use of hormone replacement therapy for peri- and post-menopausal women. Such services include consultations, examinations, and procedures related to all methods of contraception that have been approved by the United States Food and Drug Administration. Please see your *Prescription Drug Brochur*e for details of the drug coverage.

12. HOME INFUSION THERAPY

Medicare does not cover most home infusion therapies. Infusion therapy involves the administration of drugs and nutritional products that must be administered intravenously or through a feeding tube. The Plan provides coverage, less any payments made by Medicare, for the following infusion therapies administered in the Subscriber's home: (1) parenteral nutrition, (2) enteral nutrition, (3) hydration, (4) pain management, and (5) antibiotic, antifungal and antiviral therapies. Coverage includes the drug or nutritional product being infused and Medically Necessary professional services, including mid-line and peripherally inserted central catheter (PICC) line insertions.

In order to be covered under this benefit: (1) all products and services must be Medically Necessary, and (2) there must be a medical reason that appropriate drugs or nutritional products cannot be taken orally. Coverage by the Plan is only available for services that are not covered by Medicare. Please see Section III.B.2.f, above, for information on Medicare covered home health care.

13. MASSACHUSETTS MANDATED COVERAGE FOR HOSPICE CARE

In addition to the benefit for Medicare covered hospice care described in Section III.B.2.h, above, the Plan will cover hospice care that is not eligible for payment by Medicare, provided that the hospice provider is licensed by the Massachusetts Department of Public Health. To qualify for coverage, a Subscriber must have a Terminal Illness that is expected to cause or result in death despite any treatment or therapies, and receive authorization for hospice care from a licensed physician.

14. HYPODERMIC SYRINGES AND NEEDLES

The Plan will provide coverage, less any payments made by Medicare, for hypodermic syringes and needles to the extent Medically Necessary.

You must get a prescription from your physician and present it at any pharmacy for coverage. Please see your *Prescription Drug Brochure* for details. Your prescription drug Copayments are also listed on your ID Card.

15. FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT

a. Family Planning Services

The Plan covers, less any payment made by Medicare, the following family planning services:

- Annual gynecological examination
- Family planning consultation
- Pregnancy testing
- Voluntary sterilization, including tubal ligation.
- Voluntary termination of pregnancy
- Contraceptive monitoring
- Genetic counseling
- Vasectomy

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization

b. Infertility Treatment

Infertility is a medical condition defined as the inability of a presumably healthy individual to conceive or produce conception during a period of one year.

The Plan covers the following infertility treatments:

- Consultation and evaluation
- Laboratory tests
- Artificial insemination (AI), including related sperm procurement and banking
- The Plan also covers, less any payment made by Medicare, up to a total of 5 cycles of advanced reproductive technologies (ART) when Medically Necessary. Advanced reproductive technologies includes in-vitro fertilization including embryo placement (IVF-EP), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection (ICSI), and donor egg procedures, including related egg and inseminated egg procurement, processing and banking

Important Notice: HPHC Insurance Company, Inc. uses clinical guidelines to evaluate whether the use of ART is Medically Necessary. If you are receiving care for infertility, HPHC recommends that you review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38723.**

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization
- Any infertility treatment related to voluntary sterilization or its reversal
- Infertility treatment for Members who are not medically infertile
- Any form of surrogacy

16. MATERNITY CARE

The Plan covers the following maternity care services:

- Prenatal exams
- Diagnostic tests
- Diet regulation
- Prenatal genetic testing
- Post-partum care
- Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If the inpatient stay is less than 48 hours (or 96 hours in the case of a cesarean delivery) the Plan will cover at least one home visit by a registered nurse or certified nurse midwife.
- Nursery charges for routine services provided to a healthy newborn.

17. HEARING AIDS

100% of the first $500; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years.

IV. EXCLUSIONS FROM COVERAGE

No benefits will be provided by the Plan for any of the following:

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure*.

2. Any product or service that is not Medically Necessary.

3. Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or laws of similar purpose.

4. Any product or service that is provided to you after the date on which your enrollment in the plan has ended.

5. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.

6. Any product or service for which no charge would be made in the absence of insurance.

7. Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be covered by Medicare or by the Plan in the United States.

8. Any products or services, including but not limited to drugs, devices, treatments that are Experimental, Unproven, or Investigational. (Please see the Glossary for the definition of "Experimental, Unproven, or Investigational.")

9. Private duty nursing unless specifically listed as a Covered Service in your *Schedule of Benefits*.

10. Chiropractic care, except for manual manipulation of the spine to correct a subluxation, unless specifically listed as a Covered Service in your *Schedule of Benefits*.

11. Cosmetic surgery except for: (1) services covered by Medicare and (2) any additional services required to be covered under the Women's Health and Cancer Rights Act of 1998.

12. Rest or Custodial Care.

13. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses, except when covered by Medicare after cataract surgery.

14. Biofeedback, sports medicine clinics, or treatment with crystals.

15. Routine foot care services such as the trimming of corns and bunions, and the removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes.

16. Foot orthotics, except as required for the treatment of severe diabetic foot disease.

17. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.D.4. for the coverage provided for wigs)

18. Dental Services, including, but not limited to, restorative, periodontal, orthodontic, endodontic, prosthodontic services (including any services related to dentures), or any Dental Services relative to the treatment of temporomandibular joint dysfunction (TMJ), except that the Plan will cover the Medicare coinsurance and deductible amount for any Dental Service that has been covered by Medicare. (Please see the Glossary for the definition of "Dental Services.")

19. Services related to any form of Surrogacy. (Please see the Glossary for the definition of "Surrogacy.")

20. Ambulance services except as specified in this *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.

21. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.

22. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

23. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.

24. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare coinsurance and deductible amounts for professional services or surgery covered by Medicare for the treatment of obesity.)

25. Drugs or medications that can be self-administered unless (1) coverage for such drug or medication is provided for in the *Prescription Drug Brochure*, (2) the drug or medication is covered by Medicare or (3) coverage for the drug or medication is mandated by Massachusetts law.

26. Educational services and testing. No benefits are provided for educational services intended; (1) to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities, except as provided by the Massachusetts Early Intervention mandate.

27. Planned home births.

28. Transsexual surgery or any related drugs and procedures.

29. Devices or special equipment needed for sports or occupational purposes.

30. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this *Benefit Handbook*.

31. Acupuncture, aromatherapy, or alternative medicine unless specifically listed in the S*chedule of Benefits*

32. Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.

33. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")

34. Any charges for a liver, lung, heart or heart-lung transplant that is not provided at a Hospital approved by Medicare for the type of transplant required.

35. Health resorts, recreational programs, camps, wilderness programs, including any services provided in conjunction with, or as part of such types of programs.

36. Group diabetes training, educational programs or camps.

37. Massage therapy when performed by anyone other than a licensed physical therapist/certified occupational therapy assistant.

38. Myotherapy.

V. REIMBURSEMENT AND CLAIMS PROCEDURES

A. INTRODUCTION

This section explains how to obtain payments for Covered Services from the Plan. Because Plan benefits generally depend upon the coverage provided by Medicare, Providers must bill Medicare for services covered by Medicare before billing the Plan.

The Plan will usually cover benefits by making payments directly to service providers. However, there are times when the Plan will pay you instead. This might occur, for example, when you have already paid the Provider for a Covered Service or when a Provider does not accept Medicare assignment. In such cases, the Plan may pay benefits directly to you.

Claims will be paid minus the Copayment, if applicable, that is listed in your *Schedule of Benefits*. All payments by the Plan are limited to the Payment Maximum described in the Subsection J, below. You are responsible for any amount billed by a Provider that is in excess of the Payment Maximum**.**

Claims will be reviewed within 45 days of receipt. If a claim cannot be paid within that time, the plan will either notify the Subscriber (1) that additional documentation is needed or (2) that the claim is denied, in whole or in part, and the reasons for denial. If the Plan does not provide such notice, interest will be payable to the Subscriber at the rate of 1.5% per month (not to exceed 18% per year) on the amount of benefits payable, beginning 45 days after receipt of the claim. No interest will be payable on any claim that the Plan is investigating because of suspected fraud.

B. THE ADDRESS FOR SUBMITTING CLAIMS

All claims for benefits, except pharmacy, mental health and substance abuse claims, must be submitted to the Plan at the following address:

Medicare Enhance Claims
HPHC Insurance Company, Inc.
P.O. Box 699183
Quincy, MA 02269-9183

All claims for mental health and substance abuse should be mailed to:

HPIC - Behavioral Health Access Center
C/O UBH
P.O. Box 31053
Laguna Hills, CA 92654-1053

Requests for the reimbursement of pharmacy expenses must be sent to:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Please see Subsection G, below, for information on filing pharmacy claims.

C. CLAIMS FOR SERVICES COVERED BY MEDICARE PART A (HOSPITAL COVERAGE)

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part A, also known as Medicare Hospital Insurance. Medicare Part A services include inpatient care received in hospitals, skilled nursing facilities (SNFs) and Religious Nonmedical Health Care Institutions (RNHCIs). Medicare Part A also covers hospice services and some home health care.

Use this procedure to file a claim for any inpatient service that is, or may be, eligible for coverage by Medicare Part A. See Subsections E ("Claims for Services Not Covered By Medicare") and F ("Claims for Services Received in a Foreign Country"), below, for information on how to file a claim for an inpatient service that is not covered by Medicare. To obtain benefits for services under Medicare Part A, please follow these steps:

1. Bill Medicare First. Claims for Medicare Part A services should first be submitted to Medicare. Medicare will either pay the claim, in whole or in part, or deny coverage. You will be sent a Medicare Summary Notice (MSN). The MSN states the payment made by Medicare and explains any amount that was denied.

2. Then Bill Medicare Enhance. After the Medicare Summary Notice (MSN) is received from Medicare, the Subscriber or Provider must send each of the following items to the Plan to the address listed above:
   i. A copy of the Medicare Summary Notice (MSN); and
   ii. A standard UB-04 claim form completed by the Provider. (If a completed UB-04 claim form cannot be submitted, please see below.)

If a completed UB-04 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Provider's name and address, the Provider's tax identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim.

The Plan may require the submission of additional information on some claims.

D. CLAIMS FOR SERVICES COVERED BY MEDICARE PART B

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part B, also known as Medicare Medical Insurance. Medicare Part B covers most outpatient services including most physician care, diagnostic tests, outpatient surgery, outpatient mental health care, physical, occupational and speech-language therapy and durable medical equipment.

1. PROVIDER BILLING FOR PART B SERVICES

Health care professionals, such as physicians, and suppliers of health care equipment and supplies, may bill for Medicare covered services using one of two billing methods. These are that a Provider may either (1) "accept assignment" or (2) "not accept assignment" from Medicare. The following information on these billing methods is provided, for informational purposes only, to assist you in understanding your medical bills and the coverage available from the Plan. Please see the Medicare publication, *Medicare and You* for additional information on assignment and the limits that apply to Provider charges.

a. The Assignment Method Under Medicare

If a Provider accepts assignment from Medicare, the Provider agrees that he or she will accept Medicare's approved (or "allowable") amount as payment in full for the service rendered. When a physician accepts assignment the physician may not bill for more than the Medicare allowable amount and Medicare will pay the physician directly.

When a Provider accepts assignment, physician payment generally works as follows: The Provider bills Medicare. Medicare pays the Provider directly and send you a Medicare Summary Notice (MSN) explaining the payment. Then, either you or the Provider files a claim with the Plan for the balance due the Provider. For most physician services the Plan covers any unmet Medicare deductible amount and the 20% Medicare coinsurance amount, minus any Copayment you owe.

b. The Non-Assignment Method Under Medicare

If a Provider does not accept assignment from Medicare, the Provider may charge you more than the Medicare approved amount. If the Provider selects that option, Medicare will not pay the Provider directly. Medicare will pay benefits to the Subscriber and the Subscriber is responsible for paying the Provider.

When a Provider does not accept assignment, physician payment generally works as follows: The Provider bills Medicare. Medicare pays you and sends you a Medicare Summary Notice (MSN) explaining the payment. In most cases, you then file a claim with the Plan. For most physician services the Plan covers any unmet Medicare deductible amount and the 20% Medicare coinsurance amount, minus any Copayment you owe. The 20% coinsurance amount paid by the Plan is based on the Medicare approved amount, not the Provider's actual charge. If the Provider charged you an amount in excess of the Medicare approved amount, you are responsible for paying that excess to the physician.

2. BILLING THE PLAN

After Medicare has been billed and sent you a Medicare Summary Notice (MSN) for a Medicare Part B service, you or the Provider may file a claim with the Plan for any copayment and deductible amounts that have not been paid by Medicare. Since the Plan covers some services that are not covered by Medicare, you may also bill the Plan for services that Medicare has denied.

To file a claim with the Plan, the Subscriber or Provider must send each of the following items to the Plan to the address listed in Subsection B, above:

1. A copy of the Medicare Summary Notice (MSN); and
2. A standard CMS 1500 claim form completed by the Provider. (If a completed CMS 1500 claim form cannot be submitted, please see below.)

If a completed CMS 1500 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Provider's name and address, the Provider's tax identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim

The Plan may require the submission of additional information on some claims.

E. CLAIMS FOR SERVICES NOT COVERED BY MEDICARE

The Plan covers a number of services that are not covered by Medicare. These services are described in Sections III.C ("Preventive Care Services") and III.D ("Additional Covered Services"), above, and in your *Schedule of Benefits*. In addition, professionals or institutions that are not eligible to bill Medicare may provide certain Covered Services under the Plan. This section describes how to file a claim for a service that is not covered by Medicare.

Whenever possible, your Providers should first bill Medicare for the services you receive. Submission of a

Medicare Summary Notice (MSN), even if Medicare denies coverage, will prevent delays in the processing of claims that might be eligible for Medicare coverage. To bill the Plan for a service that is not covered by Medicare, please follow the procedure outlined below. For Covered Services rendered outside the United States, please follow the procedures outlined in the next section.
To file a claim with the Plan for a service that is not covered by Medicare, the Subscriber or Provider must send each of the following items to the Plan to the address listed in Subsection B, above:

1. A copy of the Medicare Summary Notice (MSN), if one has been issued; and
2. A standard claim form, such as a CMS-1500 or UB-04 claim form, completed by the Provider. (If a completed CMS-1500 or UB-04 claim form cannot be submitted, please see below.)

If a standard claim form, such as a CMS-1500 or UB-04 claim form, cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Provider's name and address, the Provider's tax identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim.

The Plan may require the submission of additional information on some claims.

F. CLAIMS FOR SERVICES RECEIVED IN A FOREIGN COUNTRY

To file a claim with the Plan for services received while traveling in a foreign country, the Subscriber must send the Plan an itemized bill for the service rendered to the address listed in Subsection B, above. The itemized bill must contain the following: The Provider's name and address, the date the service was rendered, a description of the service, and the amount of the claim.

The Plan may require the submission of additional information on some claims. The Plan may also require that the Subscriber provide an English translation of the itemized bill.

Payments for services provided outside the United States will be made only to the Subscriber. The Subscriber is responsible for paying the Provider.

G. PHARMACY CLAIMS

Please consult your *Prescription Drug Brochure* for the details of your coverage. As explained in that Brochure, you should only need to file a claim for the reimbursement of covered pharmacy expenses if you do not use a participating pharmacy. In that event, you will have to pay the retail price for the medication and submit a claim for reimbursement.

In order to process a claim for the reimbursement of pharmacy expenses you will need to submit a drug store receipt with the following information: (1) the Subscriber's name, (2) the Subscriber's Plan ID number, (3) the name of the drug or medical supply, (4) the NDC number, (5) the quantity purchased, (6) the number of days supply, (7) the date the prescription was filled, (8) the prescribing physician's name, (9) the name and address of the pharmacy, and (10) the amount paid. The Plan may require the submission of additional information to process some claims.

Requests for pharmacy reimbursement must be sent to:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Subscribers may contact the MedImpact help desk at 1-800-788-2949 for assistance with pharmacy claims.

H. ASSIGNMENT OF BENEFITS

Subscribers may assign payments by the Plan to Providers by signing the appropriate section of the Provider's claim. The Plan will pay the Provider directly if benefits are assigned. If the Subscriber does not assign benefits to the Provider, the Plan will make payment for Covered Services to the Subscriber. The Subscriber will then be responsible for paying the Provider.

I. TIME LIMIT FOR FILING CLAIMS

All claims received from Providers or Subscribers for Covered Services must be submitted to the Plan at the address above within two years of the date of service, or the date of discharge if services were rendered on an inpatient basis. Whether the Subscriber or the Provider submits the claims, it is the Subscriber's responsibility to ensure that the claims are submitted within the above time frame.

J. THE PAYMENT MAXIMUM

The Plan limits the amount it will pay for any Covered Service to the "Payment Maximum." The Payment Maximum is as follows:

a. For Medicare Covered Items. If Medicare covers a product or service, the Payment Maximum is the Medicare coinsurance amount plus any unmet Medicare deductible amount. The Medicare coinsurance amount is the portion or percentage of the Medicare-approved payment amount for a product or service that a beneficiary is responsible for paying.

   In some cases, providers may bill Medicare patients for amounts that exceed the Medicare-approved payment amount. Any amount that exceeds the Medicare-approved amount is the Subscriber's responsibility and is not payable either by Medicare or the Plan. Please see the discussion of "assignment" in the Medicare publication *Medicare and You* for information on limits that apply to Provider charges.

b. For Items Not Covered by Medicare. If Medicare does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC Insurance Company (HPIC). If a Provider is under contract to HPIC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPIC, the Payment Maximum is the amount, as determined by HPIC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in the place where the product or service was rendered. If HPIC cannot reasonably determine the normal range of charges where the product or service was rendered, HPIC may utilize the normal range of charges in Boston, Massachusetts.

VI. APPEALS AND COMPLAINTS

This section explains the Plan's procedures for processing appeals and complaints concerning the benefits or services provided by the Plan. This section also explains the options available if an appeal is denied.

Please note that the appeal procedures stated below only apply to benefits of the Plan. If Medicare denies a claim, you must appeal to Medicare. Information on your Medicare appeal rights may be found on the Medicare Summary Notice, the document sent to you by Medicare that explains what action Medicare has taken on a claim.

A. HOW TO FILE AN APPEAL OR COMPLAINT

Any appeal or complaint may be filed in person, by mail, by FAX or by telephone.

Appeals or complaints, other than those concerning mental health or drug and alcohol rehabilitation services, should be submitted to:

Member Services Department
HPHC Insurance Company
1600 Crown Colony Drive
Quincy, MA 02169.

Telephone: 1-888-333-4742
FAX: 1-617-509-3085

Appeals or complaints concerning mental health or drug and alcohol rehabilitation services should be submitted to:

Behavioral Health Access Center
C/O UBH
P.O. Box 850346
Braintree, MA 02185

Telephone: 1-888-777-4742
FAX: 1-800-383-2194

B. ABOUT HPIC'S APPEAL AND COMPLAINT PROCEDURES

What are "Appeals" and "Complaints"? HPIC divides grievances into two types, "appeals" and "complaints" as follows:

- An appeal may be filed whenever a Subscriber is denied coverage by HPIC. This includes either the denial of a health service sought by a Subscriber or the denial of payment for a health service that a Subscriber has received.
- A complaint may be filed when a Subscriber seeks redress of any action taken by HPIC or any aspect of HPIC's services, other than a denial of coverage for health services.

Both appeals and complaints should be filed at the addresses or telephone numbers listed above in subsection 1.

Subscriber Representation. A Subscriber's authorized representative may file an appeal or complaint and participate in any part of the appeal or complaint process. Any notice referred to in this section will be provided to the Subscriber or, upon request, the Subscriber's representative.

A Subscriber's representative may be the Subscriber's guardian, conservator, agent under a power of attorney, health care agent under a health care proxy, family member or any other person appointed in writing to represent the Subscriber in a specific appeal or complaint to HPIC. HPIC may require documentation that a representative meets one of the above criteria.

Time Limit for Filing Appeals. A request for informal inquiry or appeal must be filed within 180 days of the date a service, or payment for a service, is denied by HPIC.

Appeals Involving Medical Necessity Determinations. Special rights apply to appeals involving medical necessity determinations. Such an appeal could involve a decision that a service (1) is not Medically Necessary, (2) is not being provided in an appropriate health care setting or level of care, (3) is not effective for treatment of the Subscriber's condition, or (4) is Experimental or Unproven. These include the right to appeal to an external review organization under contract with the Office of Patient Protection of the Department of Public Health. The procedure for obtaining external review is summarized below in subsection 6.

The Office of Patient Protection. The Office of Patient Protection of the Department of Public Health is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection also enforces health care standards for managed care organizations, answers consumers questions about managed care and monitors quality-related health insurance information relating to

managed care practices. The Office of Patient Protection can be reached at:

Department of Public Health
Office of Patient Protection
250 Washington Street
Boston, MA 02108

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site:
http://www.state.ma.us/dph/opp/index.htm

HPIC Report on Appeals and Complaints. HPIC will file an annual report on appeals and complaints with the Office of Patient Protection. After filing, the report for the prior year will be available to Subscribers upon request. A copy may be requested from the Member Services Department at the address or telephone number listed above in subsection 1.

Membership Required for Coverage. To be eligible for coverage by HPIC, a Subscriber must be duly enrolled under this Handbook on the date a service is received. A response to an informal inquiry or an appeal decision approving coverage will not be valid for services received after the termination of membership. However, payment may be made after the termination of membership for services received while membership was effective.

C. THE INFORMAL INQUIRY PROCESS

Most appeals and complaints result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, most appeals and complaints will first be considered in HPIC's informal inquiry process. However, the informal inquiry process will not be used to review a denial of coverage involving a medical necessity determination. Coverage decisions involving medical necessity determinations will be transferred directly to the formal appeal process described below in subsection 4.

During the informal inquiry process an HPIC Member Services representative will investigate an appeal or complaint and attempt to resolve it to the Subscriber's satisfaction. Whenever possible, the Member Services representative will provide the Subscriber with a response within 3 business days of receipt of the inquiry. This response will normally be communicated by telephone.

If the Member Services representative responds to an inquiry within 3 business days of receipt but the inquiry is not resolved to the Subscriber's satisfaction, the Subscriber may either file a formal complaint or appeal, as appropriate.

If the Member Services representative cannot respond to the inquiry within 3 business days, HPIC will transfer the inquiry to the formal appeal or formal complaint process, as appropriate.

D. THE FORMAL APPEAL PROCESS

HPIC's internal appeal process is available whenever a Subscriber is denied coverage by HPIC. This includes either the denial of a health service sought by a Subscriber or the denial of payment for a health service that a Subscriber has received. If a denial involves a medical necessity determination, an appeal may be filed immediately. All other appeals will be considered in the informal inquiry process, described above in subsection 3, before an appeal is filed.

How to File an Appeal. Appeals may be filed in person, by mail, by FAX or by telephone at the addresses or telephone numbers listed in subsection 1, above. After an appeal is filed, HPIC will appoint an Appeal Coordinator who will be responsible for the appeal during the appeal process.

Documentation of Oral Appeals. If an appeal is filed by telephone, an Appeal Coordinator will write a summary of the appeal and send it to the member within 48 hours of receipt. This time limit may be extended by written mutual agreement between the Subscriber and HPIC.

Acknowledgment of Appeals. Appeals will be acknowledged in writing within 15 days of receipt by HPIC. This time limit may be extended by written mutual agreement between the Subscriber and HPIC. No acknowledgment of an appeal will be sent if an Appeal Coordinator has previously sent a summary of an appeal submitted by telephone.

Release of Medical Records. Any appeal that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Subscriber or the Subscriber's authorized representative. (When signed by an authorized representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization for Release of Medical Information form is not provided when the appeal is filed, the Appeal Coordinator will promptly send a blank form to the Subscriber or the Subscriber's representative. If a signed Authorization for Release of Medical Information is not received by HPIC within 30 business days of the date the appeal is received, HPIC may issue a decision based on the information already in the file.

What are "Pre-Service" and "Post-Service" Appeals? HPIC divides appeals into two types, "Pre-Service Appeals" and "Post-Service Appeals" as follows:

- A "Pre-Service Appeal" requests coverage of a health care service that the Subscriber has not yet received.
- A "Post-Service Appeal" requests coverage of a health care service that the Subscriber has already received.

Time Limit for Processing Appeals. For Pre-Service Appeals, Subscribers will be provided with a written appeal decision within 30 days of the date the appeal was received by HPIC. For Post-Service Appeals, Subscribers will be provided with a written appeal decision within 30 business days of the date the appeal was received by HPIC. These time limits may be extended by mutual agreement between the Subscriber and HPIC. (Any such agreement must be in writing.) Any extension will not exceed 30 business days from the date of the agreement. HPIC may decline to extend the review period for an appeal if a service has been continued pending an appeal.

If an appeal requires the review of medical information, the date of receipt will be the date HPIC receives a signed Authorization for Release of Medical Information. If HPIC does not respond to an informal inquiry within 3 business days, the date of receipt will be the 4th business day following the date HPIC received the inquiry or the date HPIC receives the signed Authorization for Release of Medical Information, whichever is later. No appeal shall be deemed received until actual receipt of the appeal by HPIC at the appropriate address or telephone number listed in subsection 1, above.

If HPIC does not act on an appeal within 30 business days plus any extension of time mutually agreed upon in writing by the Subscriber and HPIC, the appeal will be deemed to be resolved in favor of the Subscriber.

Medical Records and Information. The Appeal Coordinator will try to obtain all information, including medical records, relevant to the appeal. Due to the limited time available for the processing of appeals, Subscribers may be asked to assist the Appeal Coordinator in obtaining any missing information or to extend the appeal time limit until such information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the appeal time limit, the appeal may be decided without the missing information.

Continuation of Services Pending Appeal. If an appeal is filed concerning the termination or reduction of coverage for ongoing treatment, such coverage will be continued through the completion of HPIC's internal appeal process if:

a. The service was authorized by HPIC prior to a request for an informal inquiry or the filing of an appeal;

b. The service was not terminated or reduced due to a benefit limit under this Handbook; and

c. The appellant is, and continues to be, enrolled in this Plan.

The Appeal Process. Upon receipt of an appeal, HPIC will review, investigate and decide an appeal within the applicable time limit unless the time limit is extended by mutual agreement.

The Appeal Coordinator will investigate the appeal and determine if additional information is required from the Subscriber. Such information may include medical records, statements from doctors, and bills and receipts for services the Subscriber has received. The Subscriber may also provide HPIC with any written comments, documents, records or other information related to the claim. Should HPIC need additional information to decide an appeal, the Appeal Coordinator will contact the Subscriber and request the specific information needed.

Appeals that involve a medical necessity determination will be reviewed by a health care professional in active practice in a specialty that is the same as, or similar to, the medical specialty that typically treats the medical condition that is the subject of the appeal. The health care professional conducting the review must not have either participated in any prior decision on the Subscriber's appeal or be the subordinate of such a person.

HPIC will make a decision following the investigation and review of the appeal. In making a decision, HPIC will consider the following review criteria: (1) the benefits and the terms and conditions of coverage stated in this Handbook; (2) the views of medical professionals who have cared for the member; (3) the views of any specialist who has reviewed the appeal; (4) any relevant records or other documents provided by the Subscriber; and (5) any other relevant information available to HPIC.

HPIC's decision of an appeal will be sent to the Subscriber in writing. The decision will identify the specific information considered in your appeal and an explanation of the basis for the decision with reference to the plan provisions on which the decision was based. If the decision is to deny coverage based on an Medical Necessity determination, the decision will include:

(1) the specific information upon which the decision was based; (2) the Subscriber's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (3) identification of any alternative treatment option covered by HPIC; and (4) the applicable clinical practice and review criteria information relied on to make the decision. The decision will also include a description of other options available for further review of the appeal. These options are described in Section 6, below.

No one involved in the initial decision to deny a claim under appeal will be a decision-maker in any stage of the appeal process. Subscribers have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and appeal.

E. THE EXPEDITED APPEAL PROCESS

Subscribers may obtain expedited review of certain types of appeals. An expedited appeal may be requested if HPIC denies coverage for health services involving: (1) continued hospital care, (2) care that a physician certifies is required to prevent serious harm, or (3) a subscriber with a terminal illness. An expedited appeal will not be granted to review a termination or reduction in coverage resulting from (1) a benefit limit or cost sharing provision of this Handbook or (2) the termination of HPIC membership.

Subscribers may request an expedited appeal – other than an appeal involving mental health or drug and alcohol rehabilitation services – by contacting HPIC orally or in writing at the following address or telephone numbers:

Member Appeals
HPHC Insurance Company
1600 Crown Colony Drive
Quincy, MA 02169

Telephone: 1-888-333-4742
FAX: 1-617-509-3085

Subscribers may request orally or in writing an expedited appeal that involves a mental health or drug and alcohol rehabilitation service by contacting:

Behavioral Health Access Center
C/O UBH
P.O. Box 850346
Braintree, MA 02185

Telephone: 1-888-777-4742
FAX: 1-800-383-2194

HPIC will make a decision of an expedited appeal within 72 hours from receipt of the appeal unless a different time limit is specified below. If HPIC does not act on an expedited appeal within the time limits stated below, including any extension of time mutually agreed upon in writing by the Subscriber and HPIC, the appeal will be deemed to be resolved in favor of the Subscriber. HPIC's decision will be sent to the Subscriber in writing.

The circumstances and procedures under which Subscribers may obtain an expedited appeal by HPIC are as follows:

a. Hospital Discharge

A Subscriber who is an inpatient in a hospital will be provided with an expedited review of any action by HPIC to terminate or reduce coverage for continued hospital care based upon the medical necessity of the hospitalization or the services provided. Any such appeal will be decided prior to the termination or reduction of HPIC coverage for the Subscriber's hospital stay. Coverage for services will be continued through the completion of the HPIC appeals process. HPIC will provide the Subscriber with written notification of the appeal decision prior to discharge from a hospital

b. Services or Durable Medical Equipment Required to Prevent Serious Harm

An expedited review will be provided for appeals for services or durable medical equipment that, if not immediately provided, could result in serious harm to the Subscriber. "Serious harm" means circumstances that could (1) jeopardize the life or health of the Subscriber, (2) jeopardize the ability of the Subscriber to regain maximum function, or (3) result in severe pain that cannot be adequately managed without the care or treatment requested.

An expedited review will be provided in any case in which HPIC has denied coverage for a service or durable medical equipment if the physician recommending the treatment or durable medical equipment provides HPIC with a written certification stating that:

i. The service or durable medical equipment is Medically Necessary;

ii. A denial of coverage for the service or durable medical equipment would create a substantial risk of serious harm to the Subscriber; and

iii. The risk of serious harm is so immediate that the provision of the services or durable medical equipment should not await the outcome of the normal appeal process.

Any such certification must contain the name, address and telephone number of the certifying physician and his or her signature. Certifications may be delivered in person, by mail or by FAX at the addresses and telephone numbers listed above in this subsection. Upon receipt of a proper certification, HPIC will review the denial of coverage and provide the Subscriber with notice of the decision within 48 hours. A decision may take place earlier than 48 hours for durable medical equipment if (1) a request for such early reversal is included in the certification and (2) the physician's certification includes specific facts indicating that immediate and severe harm to the Subscriber that will result from a 48-hour delay.

c. Subscriber With a Terminal Illness

If a Subscriber with a terminal illness files an appeal of a denial of coverage, a decision will be made by HPIC within 5 business days of receipt of the appeal. A terminal illness is an illness that is likely to cause death within 6 months.

If a decision is made on appeal to deny coverage to a Subscriber with a terminal illness, HPIC will provide the Subscriber with a written decision letter within 5 business days of the decision. The decision letter will include:

1. A statement of any medical and scientific reasons for the denial; and

2. A description of any relevant alternative treatment, services, or supplies covered by HPIC.

If a decision is made on appeal to deny coverage to a Subscriber with a terminal illness, the Subscriber may request a meeting with an HPIC review committee to reconsider the denial. The meeting will be held within 10 days of request, unless the treating physician requests that it be held earlier. In such event, the meeting will be held within 5 business days. At the meeting the Subscriber and the committee will review the information previously provided in response to the Subscriber's appeal. The review committee will have authority to approve or deny the appeal. The review committee's decision will be the final decision of HPIC.

F. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have a number of options for further review. These options may include (1) reconsideration of appeals that involve a Medical Necessity determination (as described in Section VI.B.) by an HPIC review committee, (2) external review by an independent organization appointed by the Office of Patient Protection, or (3) legal action. Below is a summary of these options.

1. RECONSIDERATION BY HPIC

If a Subscriber disagrees with a decision concerning an appeal that involves a Medical Necessity determination, the Subscriber may request reconsideration of such appeal by the HPIC review committee. The Subscriber must request reconsideration within 15 days of the date of HPIC's letter denying the appeal. Reconsideration is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook

- Decisions involving excluded services, except Experimental, Unproven, or Investigational services, and

- Decisions concerning Member cost sharing requirements

The Subscriber may request that the committee review the appeal based upon the documents and records in the appeal file without participating in the meeting. Alternately, the Subscriber, or the Subscriber's representative, may participate in the committee's meeting via telephone conference call to discuss the appeal.

Subscribers are welcome to provide HPIC with any additional documents or records concerning the Subscriber's appeal prior to the meeting. The HPIC review committee will provide the Subscriber with a written decision of their review of the Subscriber's appeal.

HPIC's reconsideration process is voluntary and optional. A Subscriber may request reconsideration by HPIC before or after seeking any other dispute resolution process described below. The only exception involves appeals that have been accepted by the Office of Patient Protection for external review. For example a Subscriber may request reconsideration of an appeal before seeking external review from the Office of Patient Protection, or the Subscriber may proceed directly to external review. A Subscriber may also request reconsideration if the Office of Patient Protection has determined that an appeal is not eligible for external review. However, HPIC will not reconsider an appeal that has been accepted for external review by the Office of Patient Protection.

Reconsideration by an HPIC review committee will not affect the Subscriber's rights to any other benefits. A Subscriber's authorized representative may act on their behalf, and file a request for reconsideration and participate in the review committee's meeting. On reconsideration, the HPIC review committee will make an impartial evaluation of the Subscriber's appeal based on the review criteria in subsection 4 above without deference to any prior decisions made on the claim.

HPIC will not assert that a Subscriber has failed to exhaust administrative remedies because the Subscriber has chosen not to seek reconsideration of an appeal that has been denied under the formal appeal process. HPIC also agrees that any statute of limitations or defense based on timeliness is tolled during the time period in which a request for reconsideration is pending.

No fees or costs will be charged by HPIC for reconsidering an appeal decision.

2. EXTERNAL REVIEW

Any Subscriber who wishes to contest a final appeal decision involving a medical necessity determination may request external review of the decision by an independent organization under contract with the Office of Patient Protection of the Department of Public Health. To obtain external review, a written request for external review must be filed with the Office of Patient Protection within 45 days of receipt of the written notice of the appeal decision by HPIC. A copy of the external review form will be enclosed with your notice from HPIC of its decision to deny your appeal.

A request for an external review must meet the following requirements:

1. The request must be submitted on the Office of Patient Protection's application form called, "Request for Independent External Review of a Health Care Decision." A copy of this form may be obtained by calling the Member Services Department at 888-333-4742. It may also be obtained from the Office of Patient Protection by calling 1-800-436-7757. In addition, copies of the form may be downloaded from the Department's website at http://www.state.ma.us/dph/opp/forms.htm.
2. The form must include the Subscriber's signature, or the signature of the Subscriber's authorized representative, consenting to the release of medical information.
3. A copy of HPIC's final appeal decision must be enclosed.
4. A fee of $25 must be paid. The Office of Patient Protection may waive this fee for extreme financial hardship.

The Office of Patient Protection will screen requests for external review to determine whether external review can be granted. If the Office of Patient Protection determines that a request is eligible for external review, the appeal will be assigned to an external review agency and the Subscriber (or Subscriber representative) and HPIC will be notified. The decision of the external review agency is binding and must be complied with by HPIC.

If the Office of Patient Protection determines that a request is not eligible for external review, the Subscriber (or Subscriber representative) will be notified within 10 business days, or in the case of requests for expedited review, 72 hours.

The Office of Patient Protection may be reached at:

Department of Public Health
Office of Patient Protection
250 Washington Street
Boston, MA 02108

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site: http://www.state.ma.us/dph/opp/index.htm

The Office of Patient Protection may arrange for an expedited external review. A request for expedited external review must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the appeal decision would pose a serious and immediate threat to the health of the insured.

If the subject of an external review involves the termination of ongoing services, the Subscriber may ask the external review panel to continue coverage for the service while the review is pending. Any request for continuation of coverage must be made before the end of the second business day following receipt of the final adverse decision. The review panel may order the continuation of coverage if it finds that substantial harm to the Subscriber's health may result from the termination of coverage. The panel may also order the continuation of coverage for good cause. Any such continuation of coverage shall be at HPIC's expense regardless of the final external review determination.

G. THE FORMAL COMPLAINT PROCEDURE

A complaint may be filed when a Subscriber seeks redress of any action taken by HPIC or any aspect of HPIC's services, other than a denial of coverage for health services. All complaints will initially be considered through the informal inquiry process described above in subsection 3.

Complaints may be filed in person, by mail, by FAX or by telephone at the addresses or telephone numbers listed in subsection 1, above. A Member Services Representative will investigate each complaint and respond in writing.

Documentation of Oral Complaints. If a complaint is filed by telephone, a Member Services Representative will write a summary of the complaint and send it to the Subscriber within 48 hours of receipt. This time limit may be extended by mutual agreement between the Subscriber and HPIC. Any such agreement must be in writing.

Acknowledgment of Complaints. Written complaints will be acknowledged in writing within 15 days of receipt by HPIC. This time limit may be extended by written mutual agreement between the Subscriber and HPIC. No acknowledgment of a complaint will be sent if a Member Services Representative has previously sent a summary of a complaint submitted by telephone.

Release of Medical Records. Any complaint that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Subscriber or the Subscriber's authorized representative. (When signed by an authorized representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization for Release of Medical Information form is not provided when the complaint is filed, a Member Services Representative will send a blank form to the Subscriber or the Subscriber's representative. If a signed Authorization for Release of Medical Information is not received by HPIC within 30 business days of the date the complaint is received, HPIC may respond to the complaint without the missing information.

Time Limit for Responding to Complaints. Subscribers will be provided with a written response to a complaint within 30 business days of the date the complaint was received by HPIC. This time limit may be extended by mutual agreement between the Subscriber and HPIC. Any extension will not exceed 30 business days from the date of the agreement. Any such agreement must be in writing.

If a complaint requires the review of medical records, the date of receipt will be the date HPIC receives a signed Authorization for Release of Medical Information. If HPIC does not respond to an informal inquiry within 3 business days, the date of receipt will be the fourth business day following the date HPIC received the informal inquiry. No complaint shall be deemed received until actual receipt of the complaint by HPIC at the appropriate address or telephone number listed in subsection 1, above.

If HPIC does not act on a complaint concerning benefits under this contract within 30 business days, plus any extension of time mutually agreed upon in writing by the Subscriber and HPIC, the complaint will be deemed to be resolved in favor of the Subscriber.

Medical Records and Information. The Member Services Representative will try to obtain all information, including medical records, relevant to a complaint. Due to the limited time available for processing complaints, Subscribers may be asked to assist the Member Services Representative in obtaining any missing information or to extend the time limit for response to the complaint until such information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the time limit for responding to the complaint, the Member Services Representative may respond to the complaint without the missing information.

VII. ELIGIBILITY AND ENROLLMENT

IMPORTANT NOTICE CONCERNING ENROLLMENT INFORMATION

PLEASE NOTE THAT THE PLAN MAY NOT HAVE CURRENT INFORMATION CONCERNING A SUBSCRIBER'S ENROLLMENT IN THE PLAN. THE GIC MAY NOTIFY THE PLAN OF ENROLLMENT CHANGES RETROACTIVELY. AS A RESULT, THE PLAN'S ENROLLMENT INFORMATION MAY NOT BE UP TO DATE. ONLY THE GIC CAN ACCURATELY CONFIRM MEMBERSHIP STATUS.

A. ELIGIBILITY

To be eligible to enroll, or continue enrollment, in the Plan, an individual must meet all the following requirements at all times:

1. Be enrolled in Medicare Part A and Part B and pay any premium required for continued enrollment;
2. Be enrolled through the GIC, which has entered into an agreement with HPHC Insurance Company (HPIC) for the enrollment of Subscribers in the Plan;
3 Be a resident of the United States or one of its territories; and
4. Be an individual for whom Medicare is primary to health benefits sponsored by the GIC. In general, these individuals are:
   a. Retired employees insured by the GIC who are eligible for Medicare based on age;
   b. Retired employees insured by the GIC who are eligible for Medicare based on disability; and
   c. Active or retired employees insured by the GIC who: (i) are eligible for Medicare based on end stage renal disease (also known as "ESRD" or "permanent kidney failure"), and (ii) have passed the 30-month "coordination period" that begins when an individual becomes eligible for Medicare based on ESRD.

The Plan must receive the premium amount due for the Subscriber's *Medicare Enhance* coverage from the GIC.

The Plan does not offer dependent coverage. A dependent cannot be added onto a Subscriber's Medicare Enhance contract. However, a dependent spouse or child of a Subscriber who meets all of the eligibility requirements stated above may enroll in the Plan under a separate Contract.

The Plan must receive notice of enrollment from the GIC using Plan enrollment forms or in a manner otherwise agreed to in writing by the Plan and the GIC. The Plan must receive proper notice from the GIC of any Subscriber enrollment in, or termination from, the Plan no more than 60 days after such change is to be effective, unless otherwise required by law. Please see the GIC for information on effective dates or coverage, and Plan enrollment forms.

Please note that if an individual is re-employed by the Commonwealth of Massachusetts, the municipality, or the other entity that participates in the GIC on a part time basis after retirement, the GIC must assume primary coverage for the individual (and his or her spouse) if the amount of work performed would be sufficient, based on hours, productivity or other criteria established by the GIC, to entitle an employee to coverage under the GIC's health plan for active employees. Such an individual (and his or her spouse) may not be deemed "retired" and is not eligible for enrollment in the Plan. The only exceptions apply to persons with ESRD and to Employer Groups with 19 employees or less.

B. ENROLLMENT

1. During the period established by the Plan and the GIC, individuals who meet the eligibility requirements may enroll in *Medicare Enhance* by submitting completed application forms for enrollment on the forms supplied by the GIC and the Plan.
2. Subscribers or applicants will complete and submit Plan enrollment forms and such other information as the Plan may reasonably request. Subscribers and applicants agree that all information contained in the enrollment form or other forms or statements submitted are true, correct, and complete. All rights to benefits are subject to the condition that all information provided to the Plan is true, correct, and complete.
3. By enrolling in the Plan, all Subscribers legally capable of contracting and the legal representatives of all Subscribers incapable of contracting, agree to all the terms, conditions, and provisions in this *Benefit Handbook*, including any amendments.

C. EFFECTIVE DATE OF ENROLLMENT

Subject to the payment of premiums and the Plan's receipt and acceptance of the completed enrollment form within 60 days of the enrollment date , an individual who meets the eligibility requirements stated above may be enrolled on any one of the following dates:

1. The date the individual retiree becomes enrolled in Medicare Part A and Part B;
2. The date the individual loses eligibility for health coverage through his or her spouse's employment, due to the spouse's death, loss of employment, reduction in hours, divorce, leave of absence, or retirement;
3. The date an active employee who is enrolled in Medicare Parts A and B based on ESRD completes the 30-month coordination period during which their non-Medicare health plan is the primary payer to Medicare; or
4. The GIC's Anniversary Date.

Except as otherwise provided by law, individuals are eligible for coverage under this *Benefit Handbook* as of the effective date unless the individual is a hospital inpatient on that date. If the individual is a Hospital inpatient on the effective date, coverage will begin on the individual's date of discharge.

D. IDENTIFICATION CARD

Each Subscriber will receive a *Medicare Enhance* identification card. This card must be presented along with the Medicare identification card whenever a Subscriber receives health care services. Possession of a Plan identification card is not a guarantee of benefits. The holder of the card must be a current Subscriber on whose behalf the Plan has received all applicable premium payments. In addition, the health care services received must be Covered Services. Fraudulent use of an identification card may result in the immediate termination of the Subscriber's coverage.

VIII. TERMINATION OF SUBSCRIBER'S COVERAGE

A. TERMINATION

The coverage of a Subscriber may be terminated as follows:

1. HPHC Insurance Company (HPIC) may terminate a Subscriber's coverage under the Plan for non-payment of premium by the GIC. Premium payments are due at the beginning of the coverage period. Thereafter, there is a ten-day grace period for the payment of each month's premium. HPIC will notify you in writing if your coverage is terminated for non-payment of premium by the GIC. In that event, HPIC will elect to follow one of two options: 1) continue your coverage up to the date you receive notice of termination, or 2) offer you continued coverage on a temporary basis.
2. HPIC may terminate a Subscriber's coverage under the Plan for misrepresentation or fraud, including, but not limited to:
   a. If the Subscriber permits the use of his or her *Medicare Enhance* identification card by any other person, or uses another person's card, the card may be retained by HPIC and coverage of the Subscriber may be terminated effective immediately upon written notice.
   b. If the Subscriber provides HPIC with any information that is untrue, inaccurate or incomplete, HPIC will have the right to declare this *Benefit Handbook* null and void or, HPIC, at its option, will have the right to exclude or deny coverage for any claim or condition related in any way to such untrue, inaccurate or incomplete information.
3. HPIC may terminate a Subscriber's coverage under the Plan if the Subscriber commits acts or physical or verbal abuse which pose a threat to Providers or other Subscribers and which are unrelated to the physical or mental condition of the Subscriber. HPIC will give the Subscriber notice at least 31 days before the date of termination.
4. HPIC may terminate a Subscriber's coverage under the Plan if the Subscriber ceases to be eligible under Section VII, above, including, but not limited to, the loss of Medicare Parts A or B. Coverage will terminate on the date on which eligibility ceased.
5. HPIC may terminate a Subscriber's coverage upon the termination or non-renewal of the GIC's Agreement under which the Subscriber is enrolled.
6. A Subscriber may terminate his or her enrollment under the Plan with the approval of the GIC. HPIC must receive a completed Enrollment/Change form from the GIC within 60 days of the date membership is to end.

B. REINSTATEMENT

A Subscriber's coverage will not be reinstated automatically if it is terminated. Reapplication is necessary.

C. CONTINUATION OF COVERAGE UNDER FEDERAL LAW

If you lose GIC eligibility, you may be eligible for continuation of Employer Group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact the GIC for more information if health coverage ends due to 1) bankruptcy; or 2) loss of dependency status, such as divorce. Continuation of coverage may not be extended beyond the applicable time allowed under federal law.

D. CONTINUATION OF COVERAGE UNDER MASSACHUSETTS LAW

1. CONTINUATION FOLLOWING TERMINATION OF GROUP AFFILIATION

Provided premium is received by HPHC Insurance Company, coverage under this GIC Plan shall continue for a period of thirty-one days following termination of a Subscriber's affiliation with the GIC. No coverage under this provision shall be available during any portion of such thirty-one day period if (1) the Subscriber is be entitled to similar health coverage or (2) loses coverage under Medicare Parts A or B.

2. CONTINUATION FOLLOWING INVOLUNTARY LAYOFF OR DEATH OF THE SUBSCRIBER

A Subscriber may elect to continue coverage under this GIC Plan in the event that coverage terminates due to involuntary layoff or death of the Subscriber who is the employee or retiree of the GIC. In such event, a spouse of the laid-off or diseased Subscriber who is enrolled in the Plan on the date of layoff or death shall also be entitled to continuation of coverage under this provision.

Continued coverage under this provision shall only be available if an eligible Subscriber (1) elects continuation of coverage in writing, (2) pays his or her required premium to the GIC within thirty days from the date coverage would otherwise terminate and (3) maintains

coverage under Medicare Parts A and B. The required premium will be the full amount of premium for Plan coverage, including both the amounts normally paid by the GIC and by the Subscriber.

Continued coverage under the Plan will, in no event, continue beyond the earliest of:

a. Thirty-nine weeks from the date the coverage would otherwise cease;

b. The amount of time during which the Subscriber who was the employee or retiree of the GIC was covered under the Plan prior to the beginning of coverage under this provision, if less than thirty-nine weeks;

c. The last day for which HPHC Insurance Company has received the required premium from the GIC;

d. The date the Subscriber becomes eligible for another group medical plan; or

e. The date the GIC ceases to offer the Plan.

E. CERTIFICATES OF CREDITABLE COVERAGE

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Subscribers are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the Subscriber's Group. The certificate shows how many months of coverage a Subscriber has, up to a maximum of 18 months. It also shows the date coverage ended. The Plan will automatically send this Certificate to Subscribers upon termination of enrollment. However, Subscribers may contact the Plan by calling the Member Services Department at **1-888-333-4742** at any time within 2 years from the date coverage ended to request a free copy of their certificate from the Plan.

IX. WHEN YOU HAVE OTHER COVERAGE

A. COORDINATION OF BENEFITS (COB)

Medicare Enhance benefits are in addition to benefits provided under the Medicare program. No benefits will be provided that duplicate Medicare benefits. To the extent that the Subscriber also has health benefits coverage provided by another source, the Plan will coordinate coverage with the other payer, according to Massachusetts Coordination of Benefits regulations.

Benefits under this *Benefit Handbook* and *Schedule of Benefits* will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, homeowners insurance, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all HMO and other prepaid health plans, Medical or Hospital Service Corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day.

Coordination of benefits will be based upon the reasonable and customary charge for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a Provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans.

When a Subscriber is covered by two or more Health Benefit Plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined before those of secondary plan(s) and without considering the benefits of secondary plan(s). The benefits of secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules shall decide which Health Benefit Plans are primary and secondary:

a. The benefits of the plan that covers the person as an employee or subscriber are determined before those of the plan that covered the person as a dependent.

b. The benefits of a plan, which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan, which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. If none of the above rules determines the order of benefits, the benefits of the plan which covered a person longer, are determined before those of the plan which covered a person for a shorter period of time.

   i. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

   ii. The start of a new plan does not include: (a) a change in the amount or scope of a plan's benefits; (b) a change in the entity which pays, provides or administers the plan's benefits; or (c) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

   iii. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a Subscriber of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

B. SUBROGATION

Subrogation is a means by which the Plan and other health plans recover expenses of services where a third party is legally responsible for a Subscriber's injury or illness.

If another person or entity is, or may be, liable to pay for services related to a Subscriber's illness or injury which have been paid for or provided by the Plan, the Plan will be subrogated and succeed to all rights of the Subscriber to recover against such person or entity 100% of the value of the services paid for or provided by the Plan. The Plan will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or the Subscriber's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The Plan will also be entitled to recover from a Subscriber 100% of the value of services provided or paid for by the Plan when a Subscriber has been, or could be, reimbursed for the cost of care by another party.

The Plan's right to recover 100% of the value of services paid for or provided by the Plan is not subject to reduction for a pro rata share of any attorney's fees incurred by the Subscriber in seeking recovery from other persons or organizations. The Plan's right to 100% recovery shall apply even if a recovery the Subscriber receives for the illness or injury is designated or described as being for injuries other than health care expenses. The subrogation and recovery provisions in this section apply whether or not the Subscriber recovering money is a minor.

To enforce its subrogation rights under this Handbook, the Plan will have the right to take legal action, with or without he Subscriber's consent, against any party to secure recovery of the value of services provided or paid for by the Plan for which such party is, or may be, liable.

Nothing in this Handbook shall be construed to limit the Plan's right to utilize any remedy provided by law to enforce its rights to subrogation under this Handbook.

C. MOTOR VEHICLE ACCIDENTS

When a Subscriber is involved in a motor vehicle accident, the Plan will coordinate benefits with the Subscriber's automobile insurance company. If a Subscriber is involved in a motor vehicle accident, the Subscriber must notify the attending physician(s) that the injuries are accident related. The Subscriber must also notify the Plan of the accident, the name and address of the Subscriber's automobile insurance carrier, and such other information as the Plan may reasonably request. Subscribers agree to complete the questionnaire provided by the Plan to obtain information regarding the accident.

D. DOUBLE COVERAGE

1. WORKER'S COMPENSATION/ GOVERNMENT PROGRAMS

If the Plan has information indicating that services provided to a Subscriber are covered under Worker's Compensation, their employer's liability policy or other program of similar purpose, or by a federal, state or other government agency, the Plan may suspend payment for such services until a determination is made whether payment will be made by such program. If the Plan provides or pays for services for an illness or injury covered under Worker's Compensation, their employer's liability policy or other program of similar purpose, or by a federal, state or other government agency, the Plan will be entitled to recovery of its expenses from the Provider of services or the party or parties legally obligated to pay for such services.

2. OTHER GOVERNMENT PROGRAMS

Except as otherwise provided by applicable law that would require the Plan to be the primary payer, the benefits under this *Benefit Handbook* will not duplicate any benefits to which Subscribers are entitled or for which they are eligible under any government program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for benefits provided by the Plan are payable to and may be retained by the Plan.

3. SUBSCRIBER COOPERATION

The Subscriber agrees to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits under this *Benefit Handbook* and the *Schedule of Benefits*. Such cooperation will include, but not be limited to: a) the provision of all information and documents requested by the Plan, b) the execution of any instruments deemed necessary by the Plan to protect its rights, c) the prompt assignment to the Plan of any monies received for benefits provided or paid for by the Plan, and d) the prompt notification to the Plan of any instances that may give rise to the Plan's rights. The Subscriber further agrees to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

4. ASSIGNMENT

Coverage under this *Benefit Handbook* is not assignable by any Subscriber without the written consent of the Plan.

X. MISCELLANEOUS PROVISIONS

A. COMMENCEMENT AND DURATION OF BENEFITS

1. Except when an individual is hospitalized on the date of enrollment, all benefits under the Plan begin at 12:01AM on the effective date of enrollment. No benefits will be provided for any services rendered prior to the effective date of enrollment. If the individual is a Hospital inpatient on the effective date of enrollment, coverage will begin as of the individual's date of discharge.
2. No benefits will be provided for services rendered after coverage under this *Benefit Handbook* is terminated, unless the Subscriber is receiving inpatient hospital care covered under Medicare Part A on the date of termination. In such case, benefits under the Plan will be provided for Medicare coinsurance and deductible amounts for services covered by Medicare Part A up to the date of discharge, but in no event for longer than thirty (30) days after the date of termination. No benefits will be provided after the date of termination for any service that is not covered under Medicare Part A.
3. In computing the number of days of inpatient care benefits under the Plan, the day of admission will be counted but not the day of discharge. If a Subscriber remains in a Hospital, Skilled Nursing Facility, or other facility, for his or her convenience beyond the discharge hour, any additional charge will be the responsibility of the Subscriber.

B. TERMINATION AND MODIFICATION OF BENEFIT HANDBOOK

This *Benefit Handbook*, the *Schedule of Benefits*, and the *Prescription Drug Brochure* may be amended by the Plan upon 60 days notice to the GIC or as otherwise stated in an agreement between the Plan and the GIC. Subscribers will be given written notice of any material changes in covered benefits. Amendments do not require the consent of Subscribers.

This *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* and any riders or amendment thereto, are the entire contract between you and the Plan and, as of the effective date of this *Benefit Handbook*, supersede all other agreements between you and the Plan. The *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* and any riders or amendment thereto, can only be modified in writing by an authorized office of the Plan. No other action by the Plan, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of the *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* and any riders or amendments issued by the Plan.

HPIC may terminate this *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* by giving written notice to the GIC at least 60 days before the Contract Anniversary Date or as otherwise stated in an agreement between the Plan and the GIC.

C. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

The Plan uses clinical review criteria and guidelines to make fair and consistent utilization management decisions. Criteria and guidelines are developed in accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least biennially, or more often if needed to accommodate current standards of practice.

The Plan uses the nationally recognized InterQual criteria to review elective surgical day procedures and services provided in acute care hospitals. InterQual criteria are developed through the evaluation of current national standards of medical practice with input from physicians and clinicians in medical academia and all areas of active clinical practice. InterQual criteria are reviewed and revised annually.

Criteria and guidelines used to review other services are also developed with input from physicians and other clinicians with expertise in the relevant clinical area. The development process includes review of relevant clinical literature and local standards of practice.

The Plan's Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service. Clinician Advisory Committees work in collaboration with Medical Management leadership to develop and approve utilization review criteria.

D. QUALITY ASSURANCE AND UTILIZATION REVIEW PROCEDURES

The goal of the Plan's Quality Program is to ensure the provision of consistently excellent health care, health information and service to *Medicare Enhance* Subscribers, enabling them to maintain and improve their physical and behavioral health and well-being. Some components of the quality program are directed to all Subscribers and others address specific medical issues.

The Plan does not require prior approval of services for the coverage of benefits. Retrospective utilization review may be utilized in situations where coverage is requested for services that, in the judgment of the Plan, may not be Medically Necessary.

Subscribers who wish to determine the status or outcome of utilization review decisions should call Member Services toll-free at **(888) 333-4742**.

E. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS

The Plan covers medical devices, diagnostic, medical and surgical procedures and drugs as described in your *Benefit Handbook*, *Schedule of Benefits*, and the *Prescription Drug Brochure*. This includes new devices, procedures and drugs, as well as those with new applications, as long as they are not Experimental or Unproven.

The Plan has a dedicated team of staff that evaluates diagnostics, medical therapies, surgical procedures, medical devices and drugs. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. The team researches the safety and effectiveness of these new technologies by reviewing published medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.

F. CONSENT TO DISCLOSURE OF MENTAL HEALTH INFORMATION

The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of the Medical Necessity of mental health services will be made in consultation with a licensed mental health professional.

G. LEGAL ACTIONS AND PROVIDER MALPRACTICE

No legal action may be brought against the Plan based upon this *Benefit Handbook,* or related to benefits provided by the Plan, unless brought within two (2) years from the time the cause of action arises.

The Plan will not be liable to Subscribers for injuries, loss, or damage resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any Provider, any Hospital, or any other institution or person providing health care services or supplies to any Subscriber.

H. MAJOR DISASTER, WAR, OR EPIDEMIC

In the event of a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of the Plan, the obligations of the Plan under this *Benefit Handbook* will be limited to making good faith effort to provide benefits covered by this *Benefit Handbook*.

I. NOTICES

Any notice to a Subscriber may be sent to the last address of the Subscriber on file with HPHC Insurance Company (HPIC). Any notice to HPIC should be sent to the address listed on the back page of this *Benefit Handbook*.

J. GOVERNING LAW

The *Benefit Handbook*, *Schedule of Benefits* and *Prescription Drug Brochure* shall be interpreted in accordance with the laws of the Commonwealth of Massachusetts.

XI. GLOSSARY

The Plan follows the definitions adopted by the Medicare program in providing benefits for services covered by Medicare. The following terms, as used in this Benefit Handbook, will have the meanings indicated below:

Anniversary Date

The date agreed to by the Plan and the GIC upon which the yearly GIC premium rate is adjusted and benefit changes become effective. This *Benefit Handbook*, the *Schedule of Benefits*, and the *Prescription Drug Brochure* will terminate unless renewed on the Anniversary Date.

Benefit Handbook (or Handbook)

This legal document, including the Benefit Handbook, the *Schedule of Benefits*, and the *Prescription Drug Brochure* and any applicable riders or amendments which set forth the services covered by the Plan, the exclusions from coverage and the terms and conditions of coverage for Subscribers.

Benefit Period

A Benefit Period is a way of measuring your use of services under Medicare Part A to determine Medicare coverage and your benefits under this *Benefit Handbook*. A Benefit Period begins with the first day of a Medicare covered inpatient Hospital stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a Hospital nor of a Skilled Nursing Facility (SNF). Generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital. The type of care actually received is not relevant. However, for purposes of determining when a Benefit Period starts and ends, you are an inpatient of a Skilled Nursing Facility only when your care in the Skilled Nursing Facility meets certain skilled level of care standards established by the Medicare program. Please refer to the definition of "Skilled Nursing Care."

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.

Copayments

Fees payable by Subscribers for certain Covered Services under the Plan. Copayments are payable at the time of service or when billed by the provider. The Copayments that apply to the GIC's coverage are listed in the *Schedule of Benefits*.

Covered Services

Health care services or supplies for which benefits are provided under this *Benefit Handbook*. Covered Services are described in Section III of this *Benefit Handbook,* the *Schedule of Benefits* and the *Prescription Drug Brochure*.

Custodial Care

Personal care that does not require the continuing attention of trained medical personnel. Custodial Care services assist a person in activities such as mobility, dressing, bathing, eating, food preparation, including the preparation of special diets, and taking medications that usually can be self-administered.

Dental Services

Services furnished for the care, treatment, removal or replacement of teeth or the structures directly supporting teeth.

Durable Medical Equipment

Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. However, an institution may not be considered a Subscriber's home if it meets the basic requirements of a Hospital or Skilled Nursing Facility. Durable Medical Equipment includes items such as oxygen equipment, wheelchairs, hospital beds and other items that are determined to be Medically Necessary.

Employer Agreement

The agreement between HPHC Insurance Company and the GIC under which the Employer offers *Medicare Enhance* coverage to eligible Members.

Employer Group (or Employer)

An employer that has entered into an agreement with HPHC Insurance Company for the provision of *Medicare Enhance* benefits to eligible individuals.

Experimental , Unproven, or Investigational

The Plan does not cover Experimental, Unproven, or Investigational drugs, devices, medical treatment or procedures. A service, procedure, device, or drug will be deemed Experimental, Unproven, or Investigational by the Plan for use in the diagnosis or treatment of a particular medical condition if any of the following is true:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.

The Plan will not determine that a product or service that is covered by Medicare is Experimental or Unproven if such determination would conflict with a National Coverage Decision issued the Centers for Medicare and Medicaid Services.

(The) Group Insurance Commission (GIC)

The state agency that has contracted with HPHC Insurance Company, Inc. to provide health care services and supplies for the employees, retirees, survivors, and their dependents that it insures.

Home Health Agency

A Medicare-certified agency that provides Medically Necessary Skilled Nursing Care and other therapeutic services in your home.

Home Health Care Services

Medically Necessary health care services provided at a Subscriber's residence (other than a Hospital, Skilled Nursing Facility, rehabilitation facility, Religious Nonmedical Health Care Institution) rendered by a Home Health Agency. Home health services must be provided by an organization eligible to receive payment from Medicare.

Hospice

A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supporting services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed by the state in which it is located, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services or, when used in connection with Massachusetts mandated benefits, an accredited or licensed hospital. The term "Hospital" does not include a Skilled Nursing Facility, convalescent nursing home, rest facility or a facility for the aged that primarily provides Custodial Care, including training in routines of daily living.

HPHC Insurance Company, Inc (HPIC)

HPHC Insurance Company, Inc. is the company that underwrites the Plan. HPIC may also be referred to as "we," "us" and the "Plan."

Inpatient Mental Health Facility

An inpatient mental health facility is one of the following: a general Hospital licensed to provide Mental Health services; a facility under the direction and supervision of the Massachusetts Department of Mental Health; a private mental hospital licensed by the Massachusetts Department of Mental Health; or a substance abuse facility licensed by the Massachusetts Department of Public Health.

Licensed Mental Health Professional

A Licensed Mental Health Professional is one of the following providers: physicians; psychologists; psychiatrists; psychiatric social workers; certified psychiatric nurses; psychotherapists; licensed independent clinical social workers; licensed nurse mental health clinical specialists; licensed mental health counselors; or clinical specialists in psychiatric and mental health nursing. The benefits provided under Section III.D.2 ("Massachusetts Mandated Coverage For Mental Health Care and Drug And Alcohol Rehabilitation Services") may be provided by any Licensed Mental Health Professional, including an individual who is not eligible for payment by Medicare.

Medical Emergency

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

Medically Necessary

In the case of services eligible for coverage by Medicare, Medically Necessary means that the service is reasonable and necessary in accordance with Medicare criteria. In the case of services not eligible for coverage by Medicare, Medically Necessary means that the service that is consistent with generally accepted principles of professional medical practice as determined by whether: (a) it is the most appropriate supply or level of service for the Subscriber's condition, considering the potential benefit and harm to the individual; (b) it is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and (c) for a service that is not widely used, its use for the Subscriber's condition is based on scientific evidence.

Medicare Part B Premium

The monthly premium paid by Medicare beneficiaries for coverage under Medicare Part B.

Medicare Participating Provider

A Hospital, SNF, Hospice, Home Health Agency, any other facility identified by Medicare, or a physician or physician group that satisfies Medicare's conditions of participation and enters into a participation agreement with Medicare.

Outpatient Mental Health Facility

An Outpatient Mental Health Facility is one of the following: a licensed hospital; a mental health or substance abuse clinic licensed by the Department of Public Health; a public community mental health center; a professional office; or home-based services.

Payment Maximum

The maximum amount the Plan will pay for any Covered Service. The Payment Maximum is as follows:

a. For Medicare Covered Items. If Medicare covers a product or service, the Payment Maximum is the Medicare coinsurance amount plus any unmet Medicare deductible amount. The Medicare coinsurance amount is the portion or percentage of the Medicare-approved payment amount for a product or service that a beneficiary is responsible for paying.

   In some cases, providers may bill Medicare patients for amounts that exceed the Medicare-approved payment amount. Any amount that exceeds the Medicare-approved amount is the Subscriber's responsibility and is not payable either by Medicare or the Plan. Please see the discussion of "assignment" in the Medicare publication *Medicare and You* for information on limits that apply to Provider charges.

b. For Items Not Covered by Medicare. If Medicare does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC Insurance Company (HPIC). If a Provider is under contract to HPIC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPIC, the Payment Maximum is the amount, as determined by HPIC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in the place where the product or service was rendered. (This is sometimes referred to as the "Usual Customary and Reasonable Charge"). If HPIC cannot reasonably determine the normal range of charges where the product or service was rendered, HPIC may utilize the normal range of charges in Boston, Massachusetts.

Prosthetic Devices

Prosthetic Devices replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of Prosthetic Devices are cardiac pacemakers, prosthetic lenses, breast prostheses, maxillofacial devices, colostomy bags and supplies, and prosthetic limbs.

Provider

A doctor, Hospital, health care professional or health care facility licensed and/or certified by the state or Medicare to deliver or furnish health care services. The term Provider includes but is not limited to: physicians, podiatrists, optometrists, nurse practitioners, nurse midwives, nurse anesthetists, physician's assistants, psychiatrists, psychologists, certified psychiatric nurses, clinical specialists in psychiatric and mental health nursing, psychotherapists, licensed independent clinical social workers, licensed nurse mental health clinical specialists, and licensed mental health counselors.

Skilled Nursing Care

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

1. Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

2. Must be provided directly by, or under the general supervision of, skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Skilled Nursing Facility (SNF)

A facility (or distinct part of a facility), which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or a facility for the aged, which primarily furnishes Custodial Care, including training in routines of daily living.

Special Services

Those services and supplies a facility ordinarily furnishes to its patients for diagnosis or treatment during the time the patient is in the facility. Special Services include:

1. The use of special rooms and their equipment, such as operating rooms or treatment rooms;
2. Tests and exams, including electrocardiograms, laboratory, and x-ray;
3. Use of special equipment on the facility premises, and the services of persons hired by the facility to operate the equipment;
4. Services by a person with whom the Hospital or Skilled Nursing Facility, public community mental health center, or similar facility has a contractual agreement, by salary or otherwise, in conjunction with the use of the equipment specified above;
5. Drugs, medications, solutions, and biological preparations;
6. Administration of infusions or transfusions and other charges for services related to the administration of infusions or transfusions, (excluding the cost of whole blood, packed red blood cells, and donor fees); and
7. Internal Prosthetic Devices or appliances (artificial replacements of part of the body) that are an integral part of an operation. This includes hip joints, skull plates, and pacemakers. You are also covered for breast prostheses following mastectomy and surgery for treatment of breast cancer as required by federal law. These items are covered by Medicare Part A.

Subscriber

An individual who (1) meets all applicable eligibility requirements for enrollment in the Plan, (2) is enrolled in the Plan through the GIC, and (3) for whom the premium been received by the Plan.

Schedule of Benefits

A document that accompanies this *Benefit Handbook* that summarizes the Subscriber's coverage under the Plan and states the Copayments, benefit maximums and any special benefits provided to the Subscriber by the GIC.

Surrogacy

Any procedure in which a person serves as the gestational carrier of a child with the goal or intention of transferring custody of the child after birth to an individual (or individuals) who is (are) unable or unwilling to serve as the gestational carrier. This includes both procedures in which the gestational carrier is, and is not, genetically related to the child.

Terminal Illness

A Terminal Illness is an illness that is expected to cause or result in death despite any treatment or therapies.

XII. APPENDICIES

APPENDIX A. GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

Group Health Continuation Coverage under COBRA
This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What is COBRA coverage?
COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage contact the GIC's Public Information Unit at (617) 727-2310, ext. 1, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at **www.dol.gov/ebsa.**

Who is eligible for COBRA coverage?
Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth, Municipality, or other entity ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full-time student or ceases to be a full-time student)

How long does COBRA coverage last?
By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage.

You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- Your employer no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?
Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How much does COBRA coverage cost?
Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?
If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I elect other health coverage besides COBRA?
Yes. You may have the right to enroll, within 31 days after coverage ends, in an individual health insurance policy with your current health plan without providing proof of insurability. The benefits provided under such a policy will be different from those provided by the GIC's health plans (including those provided through COBRA). You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  – The employee's job terminates or his/her hours are reduced
  – The employee or former employee dies
  – The employee divorces or legally separates
  – The employee or employee's former spouse remarries
  – A covered child ceases to be a dependent
  – The Social Security Administration determines that the employee or a covered family member is disabled, or
  – The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

APPENDIX B. IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

The Centers for Medicare Services requires that this *NOTICE OF CREDITABLE COVERAGE* be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. This notice:

- Applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- Provides information about your GIC-sponsored drug coverage and Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- Explains your options; and
- Tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

Medicare Drug Plans

The Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon *Senior Plan*, or Tufts Health Plan *Medicare Preferred* (formerly *Secure Horizons*), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage pays. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. If your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 (or the month of your 65th birthday, whichever is later) that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.medicare.gov.
- Call the Group Insurance Commission at 1-617-727-2310.

July 1, 2008

APPENDIX C. NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at **WWW.MASS.GOV/GIC**.

Required and Permitted Uses and Disclosures
We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment Activities – The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations – The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures – The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals)
- to verify agency and plan performance (such as audits)
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- for judicial and administrative proceedings (such as in response to a court order)
- for research studies that meet all privacy requirements
- to tell you about new or changed benefits and services or health care choices

Required Disclosures – The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us – In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights
You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research.
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive a separate paper copy of this notice upon request (an electronic version of this notice is on our web site at **WWW.MASS.GOV/GIC**).

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

APPENDIX D. THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.
- Service members who elect to continue their GIC health coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Group Insurance Commission.

APPENDIX E. IMPORTANT INFORMATION FROM THE GROUP INSURANCE COMMISSION ABOUT YOUR HIPAA PORTABILITY RIGHTS

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group health plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance at (617) 521-7777 or the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272.

Using Certificates of Creditable Coverage to Reduce Pre-existing Condition Exclusion Waiting Periods
Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as "pre-existing condition exclusions," apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior "creditable" coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act [FMLA] and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage.)

When You Have the Right to Specially Enroll in Another Plan
If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. **Therefore, if you have such a life event or your coverage ends, you should request special enrollment in another plan as soon as possible if you are eligible for it.**

You Have the Right Not to Be Discriminated Against Based on Health Status
A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When You Have the Right to Individual Coverage
If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more.
- Your most recent coverage was under a group health plan (shown on this certificate).
- Your group coverage was not terminated because of fraud or nonpayment of premium.
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

Harvard Pilgrim
HealthCare

1600 Crown Colony Drive
Quincy, MA 02169

1-800-333-4742
www.harvardpilgrim.org

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